

## DOCTORAL THESIS

### **The Role of Emotion Regulation in Social Anxiety A Mixed Method Approach in a Non-Clinical Child Population**

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**The Role of Emotion Regulation in Social Anxiety**  
**A Mixed Method Approach in a Non-Clinical Child Population**

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**A thesis submitted in partial fulfilment of the requirements for  
the degree of PhD**

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## Abstract

Although social anxiety disorder (SAD) in children is increasing in western societies, there is a paucity of preventative psycho-educational programmes available. This mixed method research is aimed at evaluating and refining a newly developed intervention programme for a non-clinical child population. The objective is to evaluate the role of emotion regulation (ER) in social anxiety (SA) and identify what could aid the possible prevention of this disorder. The first study employed a video task with 64 children, aged 8-11 years to explore key behavioural measures associated with high versus low (non-clinical) SA. The negative consequences of heightened SA levels and significant relationship between SA and ER informed the focus of the Emotion and Social Skills Programme for Children (ESST-C). Study Two tested the efficacy of the ESST-C in a community sample of 144 children, aged 8-11 years of which 85 children participated in the ESST-C and 59 made up the control group (CG). Participants' levels of SA and ER were assessed pre- and post- programme, and at three-month follow-up, whereas participants of the CG were only assessed at baseline and at three-month follow-up. The findings did not show a significant decrease in levels of SA and higher levels of ER in children who participated in the programme as opposed to children in the CG, except on levels of anxiety, only partly supporting the efficacy of the ESST-C. Furthermore, the results of the first two studies identified the importance of ER skills. The aim of the third study was therefore to understand ER from the child's perspective. A qualitative study was conducted on a non-clinical group of 7-12 year olds whose parents were also interviewed on their child's reactions to socially and emotionally challenging situations. The main findings of this study identified distinct ER styles related to SA, three of which are illustrated to highlight what needs to be assessed and addressed in the development of future prevention programmes for SAD with this age group. Overall, the current thesis is a step forward in the prevention of SAD in children.

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## Dedication

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## Abbreviations

CBT	Cognitive-Behavioural-Therapy
CBGT	Cognitive-Behavioural-Group-Therapy
ER	Emotion Regulation
ERICA	Emotion Regulation Index for Children
ESST-C	Emotional and Social Skills Training for Children and Adolescents
GAD	Generalised Anxiety Disorder
IPA	Interpretative Phenomenological Analysis
OCD	Obsessive Compulsive Disorder
OPQ-C	Objective Performance Questionnaire
PMR	Progressive Muscle Relaxation
PQ-C	Performance Questionnaire
SA	Social Anxiety (non-clinical)
SAD	Social Anxiety Disorder
SCAS-C	Spence Children's Anxiety Scale
SCASGAD	Generalised Anxiety Disorder Subscale
SCASSEP	Separation Anxiety Subscale
SCASSOC	Social Phobia Subscale
SCASOCD	Obsessive Compulsive Disorder Subscale
SCAS-P	Spence Children's Anxiety Scale-Parent Version
SDQ-P	Strengths and Difficulties Questionnaire-Parents Version
SDQ-T	Strengths and Difficulties Questionnaire-Teachers Version
SENCO	Special Educational Needs Coordinator
SOC PH	Social Phobia
SPAI-C	Social Phobia and Anxiety Inventory for Children
UK	United Kingdom
WLC	Wait-list Condition

*"There is in every child at every stage a new miracle of vigorous unfolding."*

*Erik Erikson (1902-1994).*

## Overview

Social Anxiety disorder (SAD) is one of the most common psychological disorders affecting individuals from an early age and resulting in severe negative consequences in various aspects of life (Arnold et al., 2003; Costello, Egger, Copeland, Erkanli, & Angold, 2011; Crozier, Gillihan, & Powers, 2011; Hudson, Rapee, Lyneham, Wuthrich, & Schneiring, 2010; Ollendick, 2009; Rao et al., 2007; Beidel, Turner, & Morris, 1999a; Buckner et al., 2008b; Essau, Conradt, & Petermann, 1999; Essau & Petermann, 2001). Despite the severity of SAD and many successful treatment programmes the utilisation rate of such treatments is rather low and there seems to be a paucity of preventative psycho-educational programmes, necessitating more accessible and affordable platforms (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Masia-Warner et al., 2005; Offord, Kraemer, Kazdin, Jensen, & Harrington, 1998; Ruscio et al., 2008).

Human emotions are one of the most powerful factors impacting upon an individual's wellbeing, both psychologically and physiologically (Kotsou, Nelis, Grégoire & Mikolajczak, 2011) including cognitive and behavioural functioning (Bebko, Franconeri, Ochsner & Chiao, 2011; Eysenck, 2004; Gross, 2013). In addition, overwhelming emotions can be incapacitating and may interfere with daily life activities and experiences (Frijda, 1986; Slee, Arensman, Garnefski & Spinhoven, 2007). They are a fundamental aspect of everyday life, affecting the individual's social and inner processes, including self-esteem and relationship satisfaction (Koole, 2009). Consequently, the ability to regulate emotions effectively is vital (Nezlek & Kuppens, 2008), specifically considering its importance in protecting against psychological disorders such as anxiety

(Cisler & Olatunji, 2012) and depression (Kemeny et al., 2012). Despite the evident importance of ER choice, this has not been directly investigated until recently. Notwithstanding this recent progress, qualitative research looking into contributing factors in prevention programmes including parents' as well as children's perceptions relevant to this issue is limited or even non-existent. Thus, understanding children's experiences of socially and emotionally challenging situations, as well as their parents' experience of them, could add valuable knowledge to the research field of intervention and prevention of SAD in children. The main objective of the present research is, therefore, to evaluate the role of emotion regulation (ER) in SA(D), using a mixed method approach, in order to inform intervention programmes for a non-clinical child population.

The current thesis will begin with a comprehensive literature review, describing Mixed Method Designs, the etiology of SAD, and the concept of ER<sup>1</sup>. It will describe the importance of qualitative measures in this field and critically evaluate the benefits and disadvantages of a mixed method approach. Secondly, it will critically consider available research that has focused on SAD as well as ER and, furthermore, outline the significant link between SAD, emotion dysregulation and psychopathology. Moreover, it will define, outline, and evaluate related constructs such as cognitive behavioural therapy (CBT) together with aspects of ER training. The literature review will further highlight factors that play a crucial role in the development and maintenance of both SAD and ER. Lastly, it will present each study of the current research project.

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<sup>1</sup> (The term ER refers to the processes by which we influence which emotions we have, when we have them, and how we experience and express them (Gross, 1998b, p. 282).

## Chapter One: Mixed Method Approach

The importance of both quantitative and qualitative research has been shown through various successful studies. The goal of mixing these two research approaches is not to replace either of them but to draw from the strengths of concentrated exploration and reduce the limitations in single method investigation. As a third research paradigm, mixed methods research can therefore aid building a bridge between their diversities (Onwuegbuzie & Leech, 2005). Despite the availability of a number of books that evaluated the methodological work on mixed methods research models (Creswell, 2003; Johnson & Christensen, 2004; Newman & Benz, 1998; Tashakkori & Teddlie, 1998, 2003), a considerable amount of work remains to be undertaken in this area. For example, the study design, data analysis, mixing and integration procedure, as well as, its philosophical positions.

Past publications, particularly in health care research include a combination of quantitative and qualitative methods (e.g., Caracelli & Riggin, 1994; Datta, 1997; Greene & Caracelli, 1997; Morgan, 1998; Tashakkori & Teddlie, 1998, 2003). Despite the advantages of applying a mixed method approach this combination does not come without its limitations. As Carey (1993) stated, integrating quantitative as well as qualitative tools enable researchers to answer questions of substantial importance. However, it is not always the most appropriate option considering their different definitions and assumptions and both approaches not necessarily studying the same phenomena. The following will critically evaluate the advantages and disadvantages, together with similarities and differences of both methodologies in more detail, while

carefully considering the benefits as well as shortcomings of applying mixed methodologies.

### *1.1 Quantitative and Qualitative Analysis – The Two Paradigms*

Quantitative Research has a number of strengths such as the testing and validating of theories that have been constructed previously about how phenomena occur, rather than why. Furthermore, it tests hypotheses that are constructed prior to data collection and, since it usually has sufficiently sized random samples the findings can be made generally applicable (Johnson & Onwuegbuzie, 2004). Generalisation of research findings can further take place when the research has been replicated on many different populations and sub-populations (although this can also apply to qualitative research). Moreover, quantitative research enables the researcher to construct situations that eliminate the conflicting influences of many variables and to credibly evaluate data collected (Sale, Lohfeld, & Brazil, 2002). The information collection is usually much faster and provides precise, quantitative, numerical data, while the analysis of the data is also relatively less time consuming compared to qualitative data analysis (e.g., due to statistical software that are used to analyse the data). In addition, the results are statistically independent of the researcher (e.g., significance, effect, size, etc.) and this methodology allows the use of a larger sample size (Johnson & Onwuegbuzie, 2004). Despite these strengths, there are some weaknesses that need to be considered as well, such as the fact that the researchers' categories and theories may not represent the understandings of local constituencies. Furthermore, other phenomena occurring may be missed by the researcher due to confirmation bias, where their focus is on testing the



theory/hypothesis, rather than the generation of theories/hypotheses from the research results. Finally, the results of quantitative analyses may be too intangible and broad for the direct application to particular situations, perspectives, and individuals (Johnson & Onwuegbuzie, 2004). Hence, other methodologies should also be considered.

Similarly, qualitative research does also come with its strengths and weaknesses. The strengths of this type of research are that it can be used to study a limited number of cases in much more depth and that the data is based on the participant's own categories of meaning. It further demonstrates an advantageous, effective method for the description of complex phenomena and the provision of individual case information, which can be more in-depth (Johnson & Onwuegbuzie, 2004). It also enables the conducting of cross-case comparisons and analysis, which broadens the application of outcomes. Furthermore, qualitative research does provide an in-depth understanding of peoples' personal experiences of phenomena (e.g., insider's viewpoint) and its description as they are situated and rooted in local contexts (e.g., Smith & Osborne, 2008). Essentially, the qualitative researcher can identify contextual factors as they relate to the phenomenon of interest. Qualitative research further helps determine how participants interpret constructs, such as self-esteem, and emotion intelligence (Sale et al., 2002). Data are usually collected in naturalistic settings, where qualitative approaches are responsive to local situations, conditions, and participants' needs. The use of qualitative methods enables the researchers to be receptive and responsive to possible changes that may occur during the study and may therefore shift their attention. It further explains how and why phenomena occur through the words and categories of the participants,

which allows the researcher to demonstrate a phenomenon more vividly. Lastly, qualitative research regulates the idiographic causation such as determining the cause of a particular event (Johnson & Onwuegbuzie, 2004).

Despite these strengths it is crucial to also acknowledge the weaknesses of this methodology. The knowledge produced through qualitative research, for example, may not generalise to other people or other settings due to its small sample size, and the difficulties it presents in making quantitative predictions. Along these lines, it also presents more challenges in testing hypotheses and theories, which could lead to lower credibility. Additionally, this methodology requires more time for data collection and analysis in comparison to quantitative research. Finally, the findings of qualitative research are more easily influenced by the researcher's personal biases and idiosyncrasies (Johnson & Onwuegbuzie, 2004). Notwithstanding the strengths and limitations of both approaches, both paradigms present some similarities as well as differences that ought to be considered.

#### *1.1.1 Commonalities and differences of the two Paradigms*

The quantitative paradigm is based on positivism, observable, and recordable data. Its ontological position states that there is only one truth, referred to as an objective reality that exists independently of human perception. Considering the fact that the investigator and participant are independent entities, this enables the investigator of studying a phenomenon, exclusive of any influence, "inquiry takes place as through a one way mirror" (Guba & Lincoln, 1994, p. 110). The aim of quantitative research is thus to measure and analyse causal relationships between variables free of any personal biases (Denzin & Lincoln, 1994).

Following structured protocols and using written or orally administered questionnaires, with a limited range of predetermined responses, is often the method of data collection. In addition, quantitative research usually involves much larger sample sizes than qualitative research. This is to ensure that the statistical methodology can be applied and that the sample is representative of a larger population (Carey, 1993).

Qualitative research on the other hand, is based on interpretivism, explaining the meaning or the reasons why an outcome has happened (Altheide & Johnson, 1994; Secker, Wimbush, Watson, & Milburn, 1995). It also uses constructivism, where the outcome is deduced from the observations (Guba & Lincoln, 1994). According to Berger and Luckmann (1966), there are multiple realities based on one's construction of reality. Moreover, reality is socially constructed and as a result constantly changing. On an epistemological level, in a critical study of validity, no external referee exists to compare the claims of divergent "truth", and there is no access to reality, that is independent of the human mind (Smith, 1983). In qualitative research the investigator and participant are interactively linked, collectively shaping the inquiry by creating findings together within the context of the situation (Guba & Lincoln, 1994; Denzin & Lincoln, 1994). In other words, no reality exists prior to investigation; rather it exists when humans no longer focus on it (Smith, 1983). Furthermore, the process, meaning, and the techniques applied in qualitative research include in-depth and focus group interviews with rather small sample sizes to produce purposeful illustrations not necessarily based on the representation of a larger population (Reid, 1996).

The underlying assumptions of these two paradigms cause dissimilarities that go beyond philosophical and methodological debates and originated in the positivism-idealism debate of the late nineteenth century (Smith, 1983). Considering the underlying differences in these paradigms it is impossible to combine these techniques without carefully acknowledging these differences. According to Yardley and Bishop (2007, p.353), “Research that mixes these methods is likely to inadvertently violate the assumptions or fail to realise the aims of one or the other approaches”. Consequently, the current research acknowledged the theoretical framework of both approaches carefully and applied qualitative analysis as a supporting role to elaborate and enhance the quantitative findings of this as well as existing research in this field (cf. Foss & Ellefsen, 2002).

Despite the various classic differences between quantitative and qualitative research, there are similarities that are occasionally overlooked. An example in essence would be the empirical observations both quantitative and qualitative research use to address research questions. Sechrest and Sidani (1995, p. 78) indicate that both methodologies, “describe their data, construct explanatory arguments from their data, and speculate about why the outcomes they observed happened as they did”. Furthermore, both research methodologies incorporate precaution in order to limit invalidities, such as confirmation biases that most likely exist in every research study (Sandelowski, 2000). According to Biesta and Burbules (2003), all research into the social sciences attempts to provide valid and justified declarations about humans and their environment regardless of paradigmatic orientation. Dzurec and Abraham (1993, p. 75) suggest, “The objectives, scope, and nature of inquiry are consistent across

methods and across paradigms”. Thus, in order to provide superior exploration and to conduct more effective investigation in today’s complex and dynamic research world, scientists must combine and complement methodologies with one another, thereby enhancing their understanding of multiple methods. Considering the strengths and weaknesses of both methodologies, research acknowledging this will enable more constructive methodologies and therefore possibly more irrefutable conclusions.

### *1.1.2 Pragmatism for Mixed Methods Research*

As mentioned above, mixed methods research, philosophically, is a further research movement, which moved past the paradigm conflicts by offering a coherent and sensible alternative. This is usually done through the use of the pragmatic method of using inductive (discovery of theories and patterns) or deductive (testing of theories and hypotheses) methodologies (e.g., de Waal, 2001). For the purpose of the current study an inductive approach was applied for the final study. The reason for use of mixed methods is to deepen our understanding in the field of SA and ER in children and endeavour to legitimate the use of multiple approaches in answering research questions, rather than restricting or constraining researchers’ choices. Hence, it presents an inclusive, complementary, and expansive form of research. In order to mix research in an effective manner, it is crucial to consider the relevant characteristics of both quantitative and qualitative research, as above. By considering the features, the fundamental principle of mixed research is established (Johnson & Turner, 2003). Accordingly, researchers should collect and analyse data using various strategies in a way that allows the combination of approaches to result in

complementary strengths and non-coinciding weaknesses (Brewer & Hunter, 1989). Consequently, the correct use of this principle provides the justification for mixing research methods due to the superior conclusions compared to the results of single method studies. The validated findings across different methods, thereby, underline the significance of the conclusions. Even in case of controversial findings, researchers will have managed to obtain greater knowledge and can adjust their interpretations and conclusions accordingly (Morgan, 1998). As a result, in the majority of cases, the aim of mixing these paradigms is to expand knowledge of the subject (Östlund, Kidd, Wengström, Rowa-Dewar, 2011).

In this respect, combining quantitative and qualitative research can deepen and strengthen both methodologies. For example, while personal accounts and words can provide meaning to numbers, integers can offer precision to narratives and words. It therefore, enables the researchers to attend to a broader and more conclusive range of research questions. By applying the strengths of one approach to overcome the weakness of another, stronger conclusions can be made through the convergence and corroboration of findings (e.g., Östlund et al., 2011). In other words, insights and understandings can be provided that might be missed when only a single method is used. Notwithstanding the strengths of applying mixed research, some weakness should be considered. Applying both quantitative as well as qualitative research methods can be challenging for a single researcher. For example, the researcher must learn about multiple methods and understand the correct way in which they can be combined, which can prolong the analysis significantly. Moreover, in the case of conflicting results it may present difficulties to interpreting the findings

appropriately (Yardley & Bishop, 2007). As a result, some methodological scholars recommend adhering to either the qualitative or quantitative paradigm.

Nevertheless, the combination of both approaches has been shown to be possible and successful due to the overarching strengths and commonalities. According to King, Keohane, and Verba (1994) both paradigms share the same logic and procedures of interpretation. Furthermore, they are united in their commitment to understanding and improving the human condition by disseminating this knowledge for practical use. They further share the commitment of precision, reliability, and critique in the research process (Reichardt & Rallis, 1994). In fact, Clarke and Yaros (1988) suggested that combining research methods is useful in some areas of research that focus on complex phenomena, and which require data from a wide perspective. Similarly, it has been contended that the intricacies of most health difficulties or social interventions, such as health education and promotion programmes (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992), necessitate the practice of extensive qualitative and quantitative methods. Taking a practical and realistic position towards mixed method research enables the use of a technique that attempts to connect the insights provided by qualitative and quantitative research. Thus, the communication between researchers, from different paradigms, is enhanced, as they attempt to advance knowledge (Maxcy, 2003; Watson, 1990). It further supports the motivation for mixing research at its most advantageous (Hoshmand, 2003), by offering the best opportunities to answer important research questions. James (1907, p. 18, cited in James, 1995) argued that “The pragmatic method is primarily a method of settling metaphysical disputes that otherwise might be interminable. . . . The pragmatic method in such cases is to

try to interpret each notion by tracing its respective practical consequences”. Whilst quantitative approaches will be more appropriate in some cases, qualitative approaches will be more suitable in others. Scholars that tend towards pragmatic research also suggest that it allows an explicitly value-orientated approach to research. It can cover many important areas, such as intervention or prevention programmes, and dealing with issues within society (Sale et al., 2002). Accordingly, mixed method research seems to accurately open up an inspiring, almost unlimited potential for research and has therefore been employed in the current research project.

To sum up, the key issues in the mixed-method debate are ontological (looking at what the “meaning” is of the research) and epistemological (considering what its theoretical validity is). Quantitative researchers perceive an objective reality as the truth, which is independent from the investigator and awaiting discovery. Qualitative research, on the other hand, is concerned with the varying type of reality based on peoples’ experiences, which involves interaction between the researcher and participant (Phillips, 1988). As such, capturing the views and experiences of participants and explaining the meaning they make of these experiences is crucial. The imperative is to gain an in-depth understanding of the significance of the research and to explain the quantitative results to support its generalizability. Therefore, and regardless of the fundamental differences, the combination of these two paradigms is not only possible but also complementary and thus a contribution to the field of research.



### *1.2 Rationale for Including Qualitative Paradigms*

By acknowledging that the inclusion of qualitative methodologies is essential, due to the in-depth examination it allows, it is possible to study how children describe and make sense of their experiences of socially and emotionally demanding situations and how their parents make sense of their experiences of their children. Quantitative research administers questionnaires, scales, and tests, in order to measure and analyse variables, whilst qualitative research emphasises data collection and analysis of personal accounts provided by people through their experience (McLeod, 2003). Fundamentally, qualitative research allows exploration of what meanings social situations and actions have for an individual by providing awareness before an explanation. In accordance with this, Morrow (2007) stresses the suitability of qualitative research methods for capturing the meanings that people make of their experiences. Furthermore, due to its exploratory and constructivist nature, qualitative research can identify unintended outcomes associated with (intervention) programmes (Nastasi & Schensul, 2005). Thus, qualitative approaches have the potential of revealing unforeseen findings (Barker, Pistrang & Elliott, 2002), which could be beneficial in distinguishing barriers and identifying the reasons for effective or ineffective interventions (Starks & Brown Trinidad, 2007).

Presently, research into SAD treatment has been predominantly quantitative with a clear focus on variables and outcome (Darbyshire, 2005). Little research has explored the experiences of socially and emotionally arduous situations for children including their parents' views. By applying a qualitative approach in this field of research it is hoped that rather than solely quantifying the outcome results of certain variables, this will facilitate a more empirical

approach into the role of ER in SA in children. Secondly, it presents a suitable approach to the exploration of children's and parents' experiences of challenging situations. This can assist in the refinement of existing and the development of new, more beneficial, programmes. At present, the number of research programmes that include children's views as key informants on health and wellbeing matters, relating to themselves, is rather scarce. From a developmental perspective, the possibility of a lack of capacity for abstract thinking in children (Burman, 1994; Walkerdine, 1993) could jeopardise valuable and truthful responses (Scott, 2000). Thus, some researchers believe that, in order to acquire reliable information on children's views, it is necessary to go through parents and professionals (Scott, 2000). Whilst this may be true in cases of young children (younger than 8 years of age), considering their cognitive development at that stage (Dockett & Perry, 2003), there is a danger of the 'exclusion of the voices of children from the political culture of the public sphere' (Kulynych, 2001, p. 259). For children aged 8 or older, however, this may not be the case and the opportunity for them to voice their own views may in fact be a significant contribution to many areas of research.

There is a growing awareness that, despite the importance and necessity of quantitative and experimental studies, such methodologies do not provide all of the information and insight required to fully understand children's experiences. Therefore, it is essential to plan and provide appropriately responsive child and youth health services (Darbyshire, 2005). Congruently, significant legal changes of the Children's Rights agenda emphasise the need for individuals' views to impact the services provided for them (Lansdown, 1994; Woodhouse, 2004). The 'participation and involvement' agenda challenges

researchers to consider methods through which children are actively involved in all aspects of the research process (Curtis, Liabo, Roberts & Barker, 2004; Devine, 2002; Mulvihill, Rivers, & Aggleton, 2000; Sloper & Lightfoot, 2003).

## Chapter Two: Social Anxiety Disorder in Children and Adolescents

### 2.1 Definition

According to the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5; American Psychiatric Association, 2013, p. 411), Social phobia<sup>2</sup> is referred to as, "a persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others". The individual thereby fears to act in a way that will be embarrassing and humiliating. Although the DSM-5 refers to the individuals recognising their fears of social situations as unreasonable and excessive, the exposure to these situations may regularly produce anxiety that may lead to panic attacks.

According to the DSM-5 (APA, 2013), individuals with various social fears (e.g., initiating conversations or socialising in large groups) tend to avoid these feared situations or suffer from intense anxiety and distress, typically lasting six months or more. Past literature suggests that the persistent fear of embarrassment in social situations can be intrusive and have debilitating effects on social, personal, and professional relationships (Beidel et al., 1999a; Buckner et al., 2008b; Essau, 2007; Essau & Petermann, 2001; Ollendick, 2009). One example may be that individuals diagnosed with SAD usually tend to avoid social or performance situations completely leading to fewer social relationships (e.g., Beidel, Turner, & Taylor-Ferreira, 1999b). This excessive fear as well as their use of avoidance strategies invariably influences the individual's

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<sup>2</sup> Social Phobia in DSM-IV has been renamed social anxiety disorder (SAD) in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This change reflects a new and broader understanding of the condition in a variety of social situations. Thus, this thesis will use the term SAD throughout. However, when non-clinical Social Anxiety (SA) is being referred to, SA will be utilised.

functioning and everyday life in a negative way (e.g., Mikolajczak, Nelis, & Hansenne, 2008).

Despite the fact that anxiety in social situations is common and about 40% of the population refer to themselves as being shy (Carducci & Zimbardo, 1995; Henderson & Zimbardo, 1998); the severity of the distress or impairment is generally not sufficient to certify a diagnosis of SAD. To be clinically diagnosed with SAD, a sufferer often manifests a preoccupation with any kind of negative evaluation by others, especially when in the performance situations or scenarios that they fear (DSM-5, APA, 2013). Affected individuals fear judgement by other people (e.g., being regarded as anxious, injudicious, frail or irrational), which in turn initiates physical responses such as sweating, palpitations, muscle tension, trembling, and blushing (e.g., Beidel, Candice, Alfano, & Bunnell, 2013, cited in Essau & Ollendick, 2013). An illustrative example may be someone who has reservations about public speaking scenarios or about contributing to a conversation in a social scenario. The fear that other people will notice the physical signs of their anxiety and as a result end up making negative judgments about them becomes the reason for their avoidance of these situations. Rapee and Heimberg (1997) propose that, on a spectrum of concern over negative social evaluation, SAD aligns between shyness and avoidant personality disorder. They further suggest that the two poles of this spectrum are a variation of the same phenomenon instead of diverse conditions.

Further literature has revealed that SAD during childhood is highly comparable to SAD in adulthood (Beidel & Turner, 1998), yet some significant differences seem to exist. Usually the fear of embarrassing oneself by getting something wrong or exposing anxiety symptoms is found to be the most common

underlying mechanism in SAD, in children and adults. The difference in children however, is that SAD is only apparent if they experience this fear with adults as well as other peers. The way in which children have shown to express their anxiety is mostly through avoidant behaviour, severe, prolonged crying, throwing tantrums, or physical immobilisation, while adults may experience a predisposed panic attack due to their recognition of feared situations in the first instance (DSM-5, APA, 2013). Furthermore, adults diagnosed with SAD are assumed to recognise the unreasonableness and excessiveness of their fear, while children lack such awareness. Despite these differences, adults as well as children with SAD either avoid the social or performance situations that they fear or endure such situations with extreme anxiety and distress. Each of these reactions interferes significantly with the individual's natural routine, academic/occupational functioning, social activities, and relationships (Buckner et al., 2008b; DSM-5, APA, 2013; Essau, 2007; Ollendick, 2009).

Generally, individuals diagnosed with SAD excessively anticipate and evade social situations, while focussing on this apprehension of shame and humiliation (DSM-5; APA, 2013). This form of anxiety disorder has also been associated with self-presentational concerns about the way one is being evaluated and perceived by other individuals (Banerjee & Watling, 2009; Morrison & Heimberg, 2013). According to Schlenker and Leary (1982, p.645), “social anxiety arises in real or imagined social situations when people are motivated to make a particular impression on others but doubt that they will do so, because they have expectations of unsatisfactory impression-relevant reactions from others”. Thus, individuals diagnosed with SAD present bias and distorted processing of social-information and internal thoughts and beliefs that are

adduced to cause and sustain SAD (Kim & Ja Oh, 2010). Findings have shown that children, just as adults, tend to expect negative outcomes, present more negative evaluation of their own performance, and have higher levels of negative cognitions on social evaluative tasks (e.g., Alfano, Beidel, & Turner, 2006; Miers, Blöte, & Westenberg, 2010). This, in turn, not only influences their behaviour and attitude negatively, but also inhibits their social skills (e.g., failure of performing the required behaviour at that time; Rapee & Spence, 2004; Thompson & Rapee, 2002) and their academic performance (e.g., Essau & Petermann, 2001; Ollendick, Costa, & Benoit, 2010).

## *2.2 Symptoms*

The symptoms of SAD can vary depending on the individual and their cultural background (Essau, Anastassiou-Hadjicharalambous, Demetriou & Pourseied, 2013). Studies conducted in western countries, generally summarise behavioural, psychological, and cognitive responses associated with SAD in children and adolescents as follows (see Table 2.1; Beidel et al., 2013, cited in Essau & Ollendick, 2013; Heimberg, Liebowitz, Hope, & Schneier, 1995):

Table 2.1: Behavioural, Physiological, and Cognitive Responses Associated with SAD in Children and Adolescents

Behavioural	Somatic	Cognitive Thoughts
Crying	Increased heart rate	Escape
Refusal to talk	Nausea	Negative evaluation
Whining	Sweating	Failure
Hiding behind others	Shakiness	Humiliation
Clinging to parent	Breathlessness	Embarrassment
Stuttering	Numbing	Insufficiency
Fidgeting	Headaches	Self-criticism
Poor eye contact	Increased pulse	
Mumbling	Muscle tension	
Trembling voice	Butterflies in stomach	
Avoidance	Trembling	
Nervous habits		

### 2.3 Prevalence

Anxiety disorders in children are among the most common psychiatric illnesses with prevalence rates between 9%-32% during childhood and adolescence (Baumeister & Harter, 2007; Costello, Egger & Angold, 2004, 2005; Essau, Conradt, & Petermann, 2000; Essau & Gabbidon, in Essau & Ollendick, 2013; Fisak, Richard, & Mann, 2011; McLoone, Hudson, & Rapee, 2006; Merinkagas et al., 2010). In particular, SAD has a lifetime prevalence of approximately 13% of the general population (Kashdan & Herbert, 2001), making it the third most common psychiatric disorder. A small number of studies conducted among children report a prevalence of SAD between 0.6% and 3.5% with rising numbers into adulthood (Benjamin, Costello, & Warren, 1990; Merikangas, 2005). Among adolescents, findings have shown the prevalence of SAD to be



3.7% based on the adolescent's report and 6.3% based on parents' report (Verhulst, van der Ende, Ferdinand, & Kasius, 1997). Chavira, Stein, Bailey, and Stein (2004) stated the prevalence rates of SAD to be between 7% and 13% for individuals across their lifetime, indicating a noteworthy increase. While, Crozier and colleagues (2011) suggest prevalence estimates to range from 1%-6% in youth samples, the meta-analysis by Costello and colleagues (2011) report an average prevalence ranging from 2.2% (ages 6-12) to 5% (ages 12-18).

Generally, adolescents seem to have lower rates of SAD as opposed to adults, but, higher rates in comparison to younger age groups (Brook & Schmidt, 2008). In clinical settings the rate of SAD was 14.9% (Last, Perrin, Hersen & Kazdin, 1992), which has increased in recent years to 29-40%, making SAD one of the most common child anxiety disorders (DSM-5; APA, 2013; Hammerness, Harpold, Petty, Menard, Zar-Kessler, Biederman, 2008; Hitchcock, Chavira, & Stein, 2009; Kessler et al., 2005a; Knappe et al., 2011). According to Hudson and colleagues (2010), within the clinical anxiety population about 60% of children aged 7-12 years meet the criteria for SAD and this is the principle complaint in about 20% of cases. The slight variations in the prevalence rates presented may be due to the nature of the samples (clinical vs. non-clinical), the different years of publication, as well as the countries in which these studies were conducted. Nevertheless, the presented prevalence rates place SAD among the most common mental health issues affecting children linked with many behavioural and psychological inhibitions (Beidel et al., 1999a, Buckner et al., 2008b; Essau & Petermann, 2001; Ollendick, 2009).

The age of onset in community and clinical samples is reported to be between 7-9 years of age (Beidel & Turner, 2007; Chavira & Stein, 2005; Last et

al., 1992), about 9.5 years (Costello et al., 2011), or as early as 5 years of age (Schneier, Johnson, Nornig, Liebowitz & Weissman, 1992). Again, the diversity in these ages may be due to the different places and years of publication of the research. Other findings suggest a bimodal pattern of mean age of onset, with peaks being at 11-15 years and 18-25 respectively (Judd, 1995; Nelson et al., 2000; Wittchen, Stein, & Kessler, 1999). Recently, Knappe and colleagues (2011) conducted a community epidemiological study and found the mean age of onset for SAD to be 13.1 years, which is in line with earlier findings by Kessler and colleagues (2005a). In contrast Dalrymple and Zimmerman (2011), who looked into a clinical sample, found the age of onset to be 11.7 years. These divergent findings may be due to the diverse populations samples (e.g., non-clinical and clinical). Commonly, however, SAD is diagnosed in children as young as 7 years of age, with severe consequences corresponding with such an early onset (e.g., further disorders and associated impairments; Dalrymple, Herbert, & Gaudiano, 2007; Stemmerger, Turner, Beidel, & Calhoun, 1995). While, some studies suggest an increase during adolescence (e.g., Weems & Costa, 2005; Westenberg, Drewes, Goedhart, Siebelink, & Treffers, 2004), others report a stable level of social fear (e.g., Gullone, King, Ollendick, 2001) or a reduction during this time (e.g., Gullone & Lane, 2002). Nevertheless, there is an early onset of this disorder, which highlights the necessity of early intervention and prevention.

The increase of SAD in certain ages is related to cumulative levels of self-consciousness aside from environmental transitions during this particular time (i.e., new schools, peer influences, puberty, etc.; Hitchcock et al., 2009). Considering the relatively high prevalence rate in children (from 3% up to 40%),

the early onset, and the associated significant impairments SAD triggers in personal, social, and academic functioning, it presents a potential risk for typical development (e.g., Beidel et al., 1999a; Keeley & Storch, 2009; Langley, Bergman, McCracken, & Piacentini, 2004) and these consequences typically have a chronic and assiduous path without treatment (Davidson, Hughes, George, Blazer, 1993; Davis, Munson, & Tarzca, 2009). Surprisingly, however, the utilisation rate of treatments and recognition of severe symptoms and impairments in children is rather low (Masia-Warner et al., 2005; Ruscio et al., 2008), particularly in primary school children (DSM-IV; APA, 2000; Essau et al., 1999). Thus, the early identification of and attendance to this disorder and heightened levels of non-clinical Social Anxiety (SA) in a preventative fashion is necessary in order to minimise the development and manifestation of clinical SAD in children.

Furthermore, the occurrence of SAD between genders is noteworthy. SAD is found to be more dominant amongst female adolescents compared to males (e.g., Essau et al., 1999; Furmark, 2002; Wittchen et al., 1999). Females not only have a higher risk of developing SAD (Burstein et. al., 2011), but they also have an increased tendency to develop more severe generalised SAD (Furmark, 2002). Similarly, earlier findings by Cohen and colleagues (1993, cited in Compton, Nelson & March, 2000) suggested girls to be more affected by SAD as opposed to boys in community samples, whereas higher prevalence rates of SAD were found among males versus females in clinical samples. Thus, more research on this matter could elaborate upon these findings.

Research has identified schools to be the most commonly feared social setting for children and adolescents diagnosed with SAD, which consequently

inhibits their school experience (Beidel et al., 1999a; Strauss & Last, 1993; Mychailyszyn et al., 2011). This is suggested to be due to the high prevalence of anxiety-provoking situations found in this setting, such as reading in class or speaking in front of unfamiliar as well as familiar people or authority figures (Beidel et al., 1999b; Rao et al., 2007). The study by Essau and colleagues (1999) summarised the most common fearful social situations among children and adolescents, and found the strongest fear in regard to the following scenarios: being negatively judged and feeling ashamed of oneself, feeling confused, anticipating something embarrassing might happen, and blushing. Moreover, test situations or public performance scenarios present commonly feared situations in children and adolescents, while the latter endorse an overall broader pattern of fears in children (such as attending parties, social gatherings with friends, phone conversations or dating; Rao et al., 2007).

This highlights the necessity for more targeted intervention strategies that are geared towards children's unique social fears. Furthermore, prevention and intervention programmes provided in school environments may be of particular need, considering that SAD often goes unnoticed by parents and in schools and is therefore rarely addressed (Weiller, Bissierbe, Boyer, Lepine, & Lecrubier, 1996). Consequently, schools might enable early identification of developing SAD in a more efficient and cost-effective way (Essau et al., 1999) and aid the early prevention of, and intervention in, this disorder.

## *2.4 Comorbidity*

SAD in children is highly correlated with school refusal, selective mutism, academic and social inhibitions, unpopularity amongst peers, and other psychiatric conditions, such as attention-deficit/hyperactivity disorder (ADHD) and major depressive disorder in youth (Bernstein, 1991; Crawley, Beidas, Benjamin, Martin, & Kendall, 2008; Essau et al. 1999; Ranta, Kaltiala-Heino, Rantanen, Marttunen, 2009; Viana, Rabian, & Beidel, 2008). Moreover, Rapee (1995) explained that in the majority of cases other conditions become apparent prior to the onset of SAD, warning that SAD in itself may be the trigger. Thus, in most cases, SAD is suggested to lead to further disorders (Fehm, Beesdo, Jacobi, & Fiedler, 2008; Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997; Ohayon & Schatzberg, 2010). In addition, Rapee and Spence (2004) claim variations in the stability of SAD, with high as well as minimal remission.

Adolescent SAD is also commonly comorbid with other anxiety disorders, depression, and substance abuse disorders (Chavira & Stein, 2005; Dalrymple & Zimmerman, 2011; Essau et al., 1999; Kim-Cohen et al., 2003; Rapee, 1995; Seligman, Goza, Ollendick, 2004; Stein et al., 2001, Wittchen et al., 1999; Wittchen & Fehm, 2003). Beidel and colleagues (1999a) studied fifty youths diagnosed with SAD and found 60% to meet criteria for a comorbid diagnosis. Among those, the highest comorbidity of 10% were found for generalised anxiety disorder (GAD), ADHD, and simple (specific) phobia, followed by a comorbidity of 6% for separation anxiety disorder, obsessive compulsive disorder (OCD), depression, and 2% for panic disorder. This is in accordance with more recent findings by Tillfors, El-Khoury, Stein, and Trost (2009), that emphasise the comorbidity of generalised SAD with depressive

symptoms, disruptive behaviours, and antisocial tendencies, supporting the notion that generalised SAD seems to be most prone to mental health comorbidity (Beesdo et al., 2007; Ruscio et al., 2008). In particular, previous literature presenting the highest comorbidity with depression in individuals with generalised SAD (Chartier, Walker, & Stein, 2003; Wittchen et al., 1999) reinforces the likelihood that SAD and depression share common vulnerability factors (e.g., genetic factors; Hettema, Neale, Myers, Prescott, & Kendler, 2006).

### *2.5 Consequences of SAD*

In addition to the comorbidity of SAD with other psychological disorders, and as introduced above, SAD has also been associated with loneliness and low levels of self-esteem (Beidel et al., 1999a; Ginsberg, La Greca, & Silverman, 1998). Concerning their physiological impairments, it has been reported that children diagnosed with SAD usually experience physical responses such as headaches, stomach aches, and even avoidant behaviour, such as school refusal or in extreme cases selective mutism (Beidel et al., 1999a; Yeganeh, Beidel, Turner, Pina & Silverman, 2003). Hence, there is a consensus among researchers that children diagnosed with SAD experience a great deal of emotional distress and deficiencies in their daily functioning, whether it is socially, academically, or within their family setting (Beidel et al., 1999a; Beidel & Turner, 2007; Muris & Field, 2011; Rapee, Schniering, & Hudson, 2009b) and the psychological repercussions are alarming. In particular, the fact that SAD is a precursor to a variety of other severe psychological disorders as discussed in the previous chapter (e.g., Chartier et al., 2003; Saavedra, Silverman, Morgan-Lopez, &

Kurtines, 2010) and is known to have deleterious impacts on natural development, highlights the necessity of the early prevention of this disorder.

### *2.5.1 Functional Impairment*

Extensive research has demonstrated further negative interferences that SAD can have with an individual's academic and professional functioning as well as personal relationships (e.g., DSM-5, APA, 2013; Essau, 2007; Keeley & Storch, 2009; Safren, Heimberg, Brown, & Holle, 1996; Turk, Heimberg, & Magee, 2008). According to the DSM-5 (2013) the marked distress and negative impact on functioning caused by SAD is part of the diagnostic criteria for the disorder. A number of researchers have found an association between SAD and constrained social interactions, academic and social impairments, and poorer perceived quality of life in individuals diagnosed with SAD along with poor developmental outcomes later in life (Fisher, Masia-Warner, & Klein, 2004; Langley et al., 2004; Saavedra et al., 2010; Safren et al., 1996; Schneier et al., 1992).

As a myriad of studies have posited, SAD has a disruptive impact on individuals' interpersonal relationships and health, and affects an individual's functioning in various areas, such as professional, social, and romantic relationships (Alden & Taylor, 2004; Beidel et al., 1999a; Bruch, Fallon & Heimberg, 2003). These issues may derive from interpersonal and ER deficits (Alden & Bieling, 1998) and/or cognitive biases (Hirsch & Clark, 2004). Other studies have shown that SAD beginning early in life relates to poor peer relations, social competence, as well as disrupted school performance (e.g., Costello et al., 2004; Verduin & Kendall, 2008; Wood, 2006). In addition, early SAD has been associated with worse prognosis and higher rates of comorbidity

with depression and substance abuse as well as impaired and lower numbers of companionships in youth (Lecrubier, & Weiller, 1997; Magee et al., 1996; Schneier et al., 1992; Vasey & Dadds, 2001). The use of alcohol and drugs in shy teenagers may be an attempt to increase confidence and comfort levels in social situations, which raises concern (Buckner, Ecker, & Proctor, 2011; Zimbardo & Radl, 1981). Affected individuals present seriously impaired interpersonal functioning, preventing them from engaging in typical childhood activities, yet, those individuals do not display behaviours that would usually alarm teachers or parents to seek help, as children with SAD, like their adult counterparts, often suffer in silence (Beidel et al., 1999a; Settiani & Kendall, 2012; Spence, Donovan, & Brechman-Toussaint, 1999). These are rather worrying findings considering the negative consequences of SAD, such as functional and behavioural impairments throughout the lifespan, emphasising the importance of prevention/early intervention programmes.

### *2.5.2 Social Skills Deficit*

Studies have posited that social skills play a key role in the development and maintenance of SAD (e.g., Inderbitzen-Nolan, Anderson, & Johnson, 2007; Miers et al., 2010; Schneider, 2009; Stopa & Clark, 1993). According to available research, youth of all ages with SAD present substantial deficits in social skills (Alfano et al., 2006; Spence et al., 1999). Equally, studies have found that individuals diagnosed with SAD present poor or inappropriate social skills (e.g., poor eye contact, mumbled speech, difficulties in initiating and maintaining conversations, inability to recognise/identify social cues) and that these, in turn, lead to negative experiences in social situations that elevate and maintain levels of SAD (Beidel et al., cited in Essau & Ollendick, 2013).



Furthermore, and in line with adult studies (e.g., Beidel & Turner, 1998), Beidel and colleagues (1999a) found that children diagnosed with SAD display significantly poorer social skills than children without psychiatric disorders, highlighting the importance of intervention programmes focusing on the enhancement of social skills. They further displayed longer speech latencies in children diagnosed with SAD. According to Kagan, Reznick, and Snidman (1987), longer latencies are characteristic of behavioural inhibition, which is detected at very early ages. Although, Beidel and colleagues (1999b) did not conclude whether such latencies lead to the development of SAD, the data indicated that these were typical of both behavioural inhibition and childhood SAD, suggesting the probability of an association between these constructs. Moreover, past research has found that the inhibitions on the development and learning of social skills derive from early social isolation (Gazelle, & Ladd, 2003; Rubin et al., 1995). This may be due to the fact that most social behaviour is acquired from actual experience of peer interactions. The lack of initiating and maintaining social relationships would, thus, enhance the risk of remaining socially isolated in children with SAD (Beidel et al., 1999b).

In addition, non-verbal communication and social perception skills deficits seem to be present in children with SAD. For example, Melfsen, Osterlow, and Florin (2000) found socially anxious children to present limited facial activity and reduced accurate facial expression in communication of emotions compared to their healthy counterparts. In line with this, Banerjee and Henderson (2001) argued that teachers rated children with SAD as poorer in contrast to healthy children in social skills that require insight into others' mental states. This supports the notion that children with SAD and associated negative

emotions present difficulties in understanding other people's mental states during social interactions and inhibited attention to external social cues and acquisition of social knowledge due to their self-focussed attention. As a result, interventions that do not include enhancement strategies for social skills jeopardise successful treatment outcomes (e.g., Albano et al., 1995; Beidel et al., 1999b). Accordingly, psychological interventions that included social skills training components have so far shown a higher success rate in treating SAD (e.g., Heimberg, 2002; Zins & Elias, 2006). The current study therefore aims to make social skills deficiencies a focus and thus to enhance the usefulness of the findings for promoting a more preventative approach to SAD by targeting a community sample of children.

### *2.5.3 Cognitive Evaluative Features*

Along with behavioural, functional, and emotional aspects associated with SAD, cognitive evaluative features play another key role. Past studies have shown social performance tasks to be useful in understanding and treating SAD in that they include how others perceive an individual (Alden & Taylor, 2004). Often, research that has included exposure tasks in social situations, utilised speech or interaction tasks, and compared individuals with and without SAD (e.g., Moscovitch & Hofmann, 2007; Voncken & Bögels, 2008). Findings of such studies suggested discrepancies between self and other ratings of the social performance, which are in agreement with cognitive theories of SAD arguing that individuals diagnosed with SAD have a biased perception of themselves (Clark & Wells, 1995; Rapee & Heimberg, 1997). Accordingly, Rapee and Lim (1992) found individuals diagnosed with SAD to underestimate their actual performance in contrast to the performance ratings of observers in speech tasks.

Literature has shown that the onset of anxiety disorders is influenced by developmental factors (e.g., Manassis, Huson, Webb, & Alfano, 2004), such as cognitive changes that can affect the development of these symptoms. For example, the changes of focus in what children fear. While very young children fear separation or noise, children in primary and particularly secondary schools are concerned about how they are being perceived by their peers (e.g., social evaluative concerns). This is in line with the notion that mood and anxiety disorders are characterised by emotional disturbances, which according to cognitive models derive from negatively biased, inaccurate, and unyielding beliefs about one's identity (Beck & Dozios, 2011; Hadwin, Garner, & Perez-Olivas, 2006). Empirical findings have supported this view and found a link between maladaptive beliefs and psychopathology (Riso, du Toit, Stein, & Young, 2007).

Alloy and colleagues (2006) argued that maladaptive beliefs play a potentially causal role in anxiety and mood disorders, although this evidence is contested (e.g., Jarrett, Vittengl, Doyle, & Clark, 2007). Nevertheless, according to existing research on cognitive models of SAD, such as by Heimberg, Brozovich, and Rapee (2010) or Rapee and Heimberg (1997), the notion that individuals diagnosed with SAD have maladaptive beliefs regarding themselves (for example, that they make a fool out of themselves and others), or believe they are critically judged by others (Bögels, van Dongen, & Muris, 2003; Stopa & Clark 1993; Weeks et al. 2005) is supported. When social situations occur, such maladaptive cognitions are activated and transformed to detrimental social cues (e.g., others disengaging during a conversation and personalising this). Accordingly the study by Schmitz, Krämer, Blechert, and Tuschen-Caffier

(2010) demonstrated an association between negative post-event processing and SAD in children. These maladaptive cognitions play a significant role in the perseverance and maintenance of SAD (e.g., Clark & Wells 1995; Kim & Ja Oh, 2010; Rapee & Heimberg 1997).

Past research has shown that negative thinking is related to SAD in children, among other things (e.g., Bögels & Zigterman, 2000; Rheingold, Herbert, & Franklin, 2003). According to Spence and colleagues (1999), children diagnosed with SAD are found to report more negative cognitions relating to task performance. They appraise their own performance more adversely, whilst undergoing social-evaluative tasks compared to healthy children. These findings are in line with more recent research suggesting that children with subclinical SAD rate themselves as performing less skilfully and feeling tense in tasks evaluating ones behaviour (e.g., talking to an unfamiliar adult or in front of a camera; e.g., Cartwright-Hatton, Hodges, & Porter, 2003; Cartwright-Hatton, Tschernitz, & Gomersall, 2005). However, it remains unclear whether the increase in negative thinking is dependent on particular SAD symptoms or diverse categories (e.g., Rapee & Spence, 2004). Accordingly, cognitive biases would already be existent with subclinical levels of SAD, while a compromised performance in a task and higher levels of noticeable fear response would only be related to high levels of full syndrome SAD.

Tuschen-Caffier, Köhl, and Bender (2011) compared the occurrence of impaired performance and cognitive-evaluative misrepresentations in children diagnosed with full syndrome SAD to children presenting only some symptoms (subclinical partial syndrome SAD) and to healthy controls undergoing such tasks. Their findings showed that children with SAD and subclinical SAD

showed more negative thinking and increased levels of anxiety than healthy children, yet there were no between-group differences concerning the performance during the task. Thus, the severity of SAD in children is related to the degree of maladaptive thinking and experienced anxiety in social-evaluative assignments.

In accordance with a great deal of research that looked into the extent to which CBT modifies the cognitions that have been observed in people with SAD, Hofmann (2000) found a significant reduction of negative self-focused attention that was correlated with decreased levels of SAD symptoms. Similarly, Wilson and Rapee (2005) observed significant reductions in negative interpretation biases following CBT and demonstrated lower propensities to prompt bad interpretations of negative social events, which were also associated with improvements in SAD symptoms. Thus, a range of maladaptive cognitions distinguish people with SAD from healthy controls and CBT has been shown to lead to significant improvements in these cognitions as well as to reduce the fear of negative evaluation in individuals diagnosed with SAD (e.g., Muris, Huijding, Mayer, Remmerswaal, & Vreden, 2009; Koerner, Antony, Young, & McCabe, 2013; Reuland & Teachman, 2014; Vassilopoulos, Banerjee, & Prantzalou, 2009). Despite the significance of maladaptive beliefs in SAD however, only a few studies seem to have looked into this (Anderson, Goldin, Kuria, & Gross, 2008; Fergus, Valentiner, Kim, & Stephenson 2009; Rapee, Gaston, & Abbott, 2009a; Turner, Johnson, Beidel, Heiser, & Lydiard, 2003).

The majority of studies exploring maladaptive beliefs in the context of CBT (DeRubeis et al., 1990; Jarrett et al., 2007) mainly focussed on depressive

disorders, neglecting panic disorder (Hofmann et al., 2007) and SAD (Rapee et al., 2009a). However, the study by Rapee and colleagues (2009a) compared patients receiving enhanced CBT treatment to standard CBT or stress management and showed that maladaptive beliefs associated with negative representations of appearance and performance were allied with central beliefs related to SAD. Patients in the enhanced treatment condition demonstrated the highest levels of reduction in negative representations versus the other two conditions, yet there was no significant difference between conditions in modifications of fundamental beliefs. As a result, in 2012, Boden and colleagues investigated whether change in beliefs explains the impact of CBT in the healing of SAD in order to explore the relations between maladaptive beliefs and SAD symptoms. After 16 weeks of individual CBT sessions their findings supported previous studies examining cognitive arbitration of treatment for SAD (Hofmann, 2004; Rapee et al., 2009a) by showing maladaptive beliefs to be associated with the severity of SAD symptoms and that these symptoms were significantly reduced from baseline to treatment completion. In addition, their findings contradicted those of Rapee and colleagues (2009a) by stating that the resulting reductions in maladaptive interpersonal beliefs through treatment significantly mediated the effect of CBT on SAD symptom severity. The disparity in findings may be due to different comparison groups. While Boden and colleagues (2012) used a wait-list condition (WLC), Rapee and colleagues (2009a) compared three active treatments, of which two contributed to a certain level of belief change.

Nevertheless, the notion that maladaptive interpersonal beliefs play a causal role in SAD and that these can be modified by CBT is supported, which is

consistent with the fact that altering maladaptive cognitions is a primary focus of CBT, which is thus a widely supported treatment for SAD (Beck & Dozios, 2011). This is consistent with findings by Ginsburg, Becker, Drazdowski, and Tein (2011) that showed young people with higher levels of maladaptive cognitions at baseline to report fewer improvements at post-treatment. As a result, children in particular might benefit from an intervention that focuses on their maladaptive beliefs concerning the way they appear to others during social scenarios (cf. Cartwright-Hatton et al., 2005; Dineen & Hadwin, 2004), which is supported by video feedback studies in adult (e.g., Harvey, Clark, Ehlers, & Rapee, 2000) and child populations (e.g., Essau, Olaya, Sasagawa, Pithia, Bray, & Ollendick, 2014). Consequently, this highlights the importance of CBT-based prevention programmes aimed at changing maladaptive self-beliefs and negative self-talk in children with excessive levels of SAD and low levels of emotion regulation (Mahone, Bruch, & Heimberg, 1993).

#### *2.5.4 Cognitive Dysfunction*

From a bio-psychological point of view, appropriate reactions to threat-related stimuli depend on the fast allocation of attention to potential sources of danger in the environment (e.g., Davis & Whalen, 2001; McNaughton & Gray, 2000). The neurocognitive mechanisms that control such processing biases have been found to be associated with the onset and course of anxiety disorders (e.g., Bar-Haim, Lamy, Pergamin, Bakermans-Kranenburg, & van IJzendoorn, 2007). For example, Kanai, Sasagawa, Chen, Shimada, and Sakano (2009) found that individuals with high levels of SAD tend to interpret other peoples' behaviours in a more negative and threatening way than individuals with low levels of SAD, suggesting that SAD is partially related to threatening interpretations of others'

ambiguous behaviours. This finding is in line with earlier results on interpretation bias in anxious individuals for ambiguous social events (e.g., Dineen & Hadwin, 2004; Hadwin et al., 2006; Stopa & Clark, 2000) and for facial expression (e.g., Schofield, Coles, & Gibb, 2007). Accordingly, research in children emerged over the past few years. Miers, Blöte, Bögels, and Westenberg (2008), for example, highlighted the tendency to choose the negative interpretation of a social situation as the correct one in socially anxious as opposed to non-anxious adolescents. Comparably, Vassilopoulos and Banerjee (2011) provided evidence that children high in SAD tend to interpret ambiguous events within a social domain as more negative than their counterparts. In a longitudinal study by Creswell and O'Connor (2011), with a community sample of children aged 10 - 11, anticipated distress response to obscure stories predicted an increase in anxiety symptoms over time. These findings underline the significant role interpretation biases play in the development of anxiety disorders in children. It is therefore important to recognise and work on specific cognitive abilities through enhanced awareness and regulation techniques to reduce the development of certain anxiety disorders. The study by Vassilopoulos and colleagues (2009) demonstrated the possibility of modifying interpretation biases in children with high levels of SAD. Their sample of primary school children received three sessions designed to influence interpretation biases in a less negative manner and presented improvements in anticipated social encounters associated with negative interpretation scores compared to non-trained controls.

Clark and Wells (1995) proposed that individuals suffering from negative self-evaluative thoughts, experienced in social situations, demonstrate a self-



focused attention and are therefore unreceptive to any possible positive aspects of the situation that may provide acceptance or positive cues from the other person. As a result, the individual's social performance is impaired and the possibility that the feared outcome will occur increases (Bögels & Mansell, 2004). Furthermore, Clark and Wells' (1995) cognitive behavioural model (which suggests that individuals are inhibited by thinking that they may behave in an unacceptable or embarrassing manner and that this behaviour may have disastrous consequences in terms of their worth and status) may help to explain why SAD can have such a distinct effect on interpersonal relationships. It suggests that the negative characteristic beliefs and behaviours possibly interfere with social behaviour. In a related vein, Stravynski (2007) claims that the distorted assumptions and expectations that evolve in individuals diagnosed with SAD, trigger physical symptoms, which reinforce the concept of danger being an integral aspect of social situations. Correspondingly, the study on eye movements by Buckner, Maner, and Schmidt (2008a) showed that socially anxious participants tend to focus their gaze longer on socially threatening pictures as opposed to non-socially anxious individuals, which further emphasises the cognitive bias toward negative social cues in individuals diagnosed with SAD.

Consistently, past findings (e.g., Kanai et al., 2009; Miers et al., 2008; Stravynski; 2007) support the cognitive-behavioural model of SAD (Clark & Wells 1995; Rapee & Heimberg 1997). Hence, the focus on changing these biased cognitions and providing children with the necessary tools to do so is essential. This is also based on the findings by Vassilopoulos and Banerjee (2011) and their earlier study (2008) where they found that children with greater

levels of SAD tend to interpret slightly negative events in a more catastrophic manner and discount positive events more in comparison to participants with lower levels of SAD. In addition, anticipated negative emotional reactions to fairly negative events increased with heightened SAD. This study however, failed to incorporate measures of actual social behaviour and interpersonal relations. These are important factors to consider as they may show that children make more negative interpretations of new social events (whether they are accurate or not), due to the fact that they may have had negative experiences in similar situations in the past. Nevertheless, the findings still remain reasonable, given that SAD has been shown to be associated with social skills deficits (e.g., Rao et al., 2007) and with poorer peer relations (e.g., La Greca & Stone, 1993) in past studies. Despite these findings and the fact that individuals diagnosed with SAD experience social interactions as difficult and fear the scrutiny of others, it is also possible that the worry experienced in such situations is the result of their disrupted interpersonal functioning, rather than their cognitive and social skills deficits per se (Kley, Tuschen-Caffier, & Heinrichs, 2011). This is another reason why preventative programmes are required from an early stage and seem more beneficial if they focus on enhancing social as well as emotional skills.

As previously mentioned, the apprehension and fear of negative evaluation by others is central to SAD (Rapee & Heimberg, 1997) and the way one evaluates oneself may be a central cognitive ability that precedes the development of SAD. Vasey, Crnic, and Carter (1994) have found worrying thoughts to occur in typical children's anxious experiences as early as five years of age. However, these thoughts were more apparent and complex in eight year olds and associated with behavioural competence and social evaluation. This is

in line with the earlier work of Bennett and Gillingham (1991), who determined that the capacity to anticipate and experience worry about negative evaluation by others is not fully established until around the age of eight. It is only during adolescence that children develop an increased understanding of social interaction and an awareness of possible negative evaluations from others (Beidel et al., 1999a; Heimberg et al., 1995). Beidel and colleagues (1999a) emphasise the increasing social demands during adolescence and the development of more complex cognitive skills during this time. Hence, this is a crucial phase of development and may be associated with the onset of SAD. It is however, noteworthy that fears and anxieties alter throughout childhood and adolescence, while corresponding to the cognitive development of the child to recognise and interpret situations as dangerous (Essau, Olaya, & Ollendick, 2013, cited in Essau & Ollendick, 2013). Therefore, attending early to psychopathological markers related to the development of SAD is crucial. There is strong empirical evidence for a significant link between cognitive biases toward threatening stimuli and anxiety levels (Hadwin et al., 2006).

Considering these crucial findings on cognitive development in SAD, researchers should draw their attention to these factors in the development of prevention and intervention programmes by increasing the individual's awareness of the irrationality of interpretation biases and by providing regulation techniques to minimise those. Especially, in respect to CBT-based programmes, certain cognitive factors require increased attention, considering that most follow-up studies show the same interpretation biases as at baseline in individuals (e.g., Saleminck & Wiers, 2011).

Existing studies compared participants with SAD to non-anxious participants using eye contact, pauses during a speech, or overall impression of their performance as parameters (Hofmann, Gerlach, Wender & Roth, 1997; Norton & Hope, 2001). Results indicated that individuals with SAD in contrast to healthy participants, and participants with other anxiety disorders, present a more negative performance in social interaction situations (Baker & Edelmann, 2002; Fydrich, Chambless, Perry, Buergener & Beazley, 1998; Voncken & Bögels, 2008). Comparably, individuals with elevated symptoms of SAD have been found to pause more frequently than healthy controls during a speech, suggesting poorer social performance (Hofmann et al., 1997). However, later studies using speech tasks yielded inconsistent results. While some research has revealed impaired performance in SAD patients when compared to healthy controls (Moscovitch & Hofmann, 2007), others did not find any differences between the two groups (Voncken & Bögels, 2008).

Consistent with Strahan and Conger (1999), who reviewed the effects of SAD on performance, the behaviour of individuals diagnosed with SAD is often comparable to the one of healthy controls. This discrepancy in findings may be based on the subjective variability in fear that is elicited from a situation. Due to high within-group variability in this fear, it may not be discernible between group differences. Hence, more studies are required in this field to conclude outcomes. In accordance with the above, other studies suggest that social performance could be contingent upon the specific situation (e.g., Rapee & Lim, 1992). Consequently, how others perceive an individual in social situations can depend on various factors, including situational anxiety, self-focussed attention, cognitive processes, and safety behaviours. It would be interesting to consider

different performance measures in a non-clinical sample of children with elevated levels of SA to enhance existing literature and demonstrate the negative effects on performance, which may support the maintenance of dysfunctional cognitions that could lead to clinical SAD.

Taken together, the results from social deficit and cognitive theories suggest that individuals diagnosed with SAD have a deficiency in managing and regulating the anxiety, rather than in their fundamental performance ability (Reid, 2008). This may be the reason why children that utilise dysfunctional strategies regulating their anxiety are more vulnerable to developing this disorder (Wittchen, et al., 1999). Clinical experiments suggest that adults diagnosed with anxiety disorder present threat bias at the earliest stage of information processing. This stage represents the unconscious activity of multimodal sensory data, which is then prioritised for conscious processing. An example is provided by anxious rather than non-anxious adults who showed increased somatic and emotional responses to images of angry versus neutral faces that were unconsciously presented (Ohman, 1996).

Research that is more recent however, highlights the environmental factors that may have an impact on early attentional processes of this kind in anxiety provoking or threatening situations (e.g., Pollak & Sinha, 2002). The study by Pollak and Sinha (2002), for example, revealed children who have suffered from physical abuse to perceive angry faces much faster, even with less visual information, in contrast to children who had no history of abuse. As a result, the conceptualised biases in children with anxiety may describe such biases as realistic representations instead. Those representations may well be

overgeneralised to other situations that may or may not be high risk (e.g., interactions with peers in school). Hence, these findings are in accordance with research suggesting that internal working models of insecurity in parent-child relationships play a role in the development of SAD in children (Fisak, & Grills-Taquechel, 2007).

## *2.6 Etiology of SAD*

### *2.6.1 Genetic Factors*

The etiology of SAD still remains unclear, due to various potential causes (see Rapee & Spence, 2004 for review). However, family studies (Hettema, Neale, & Kendler, 2001; Fyer, 1993), genetic studies (Beatty, Heisel, Hall, Levine & La France, 2002; Gregory & Eley, 2011; Kendler, Neale, Kessler, Heath & Eaves, 1992; Nelson et al, 2000) and high-risk studies (Beidel & Turner, 1997) showed that anxiety disorders could be transmitted through genes. Although Kendler and colleagues (1992) found a higher concordance rate of SAD in monozygotic rather than dizygotic twins, which is in accordance with previous studies (e.g., Nelson et al., 2000; Stein, Jang, & Livesley, 2002), no study thus far has reported the direct transmission of a particular anxiety disorder. Similarly, Stravynski (2007) claimed that there is no indication that SAD is inherited via genes. This is in contrast to research that reported children with SAD to be more likely to have parents with SAD and to be at increased risk for this disorder (Lieb et al., 2000; Mancini et al., 1996).

Several methodologically sound twin studies with large sample sizes demonstrated a significant genetic influence in the development of SAD (Nelson

et al., 2000; Stein et al., 2002), which is in line with other findings that suggest a heritability estimate of 0.4 - 0.6 (e.g., Albano & Detweiler, 2001; Ollendick & Hirshfeld Becker, 2002). These findings further indicate that the persistence of SAD is strongly under genetic influence. Accordingly Rapee and Spence (2004) stated that: “genetic factors play a modest but significant role in the development of social phobia and social anxiety, in both children and adults” (p. 744). Rosenberg and Kosslyn (2011) further proposed that a combination of genetic and environmental factors play a role in the development of SAD. In fact, the study by Kendler and colleagues (1992) showed that environmental factors rather than genetic variables seemed most predictive of the development of this disorder, highlighting the crucial role that non-biological factors play in the development of anxiety disorders.

### *2.7 Family and Environmental Factors*

Communication within the family, parental practices (observational learning and psychosocial education), family dynamics, peer relations, and negative social experiences are all environmental factors that affect the development and maintenance of SAD in children (e.g., Crosby Budinger, Drazdowski, Ginsburg, 2012; Russel, Pettit, & Mize, 1998). As an example, social experiences that are traumatic or humiliating are linked to the onset and deterioration of SAD, particularly those experiences that are related to the fear of public speaking (Beidel, 1999a, Beidel & Turner, 1998). In addition, Bögels, Van Oosten, Muris, and Smulders (2001) argued that deficiencies in family sociability increase the likelihood of SAD in children and adolescents between 8-18 years of age. This is in agreement with the findings by Katz and Low (2004), who suggested an

association between negative family interaction (e.g., conflict and disagreements) and children's anxiety and depression. Despite these findings, however, further research into the relationship between family functioning and SAD, particularly in children, is required as other family factors and parenting styles may play a role in the development and/or maintenance of SAD (cf. Hughes & Gullone, 2007).

Past literature, for instance, has revealed discipline styles and socialisation practices either to be associated with SAD or involved in the development of this disorder (e.g., Kearney, 2005; Mills & Rubin, 1998; Rapee & Melville, 1997). In particular, adults with SAD remember their parents to be less sociable and avoiding social contacts through the appliance of shame as a method of discipline (e.g., Bruch & Heimberg, 1994). These findings are in accordance with Rapee and Melville (1997), who suggested mothers of individuals diagnosed with SAD to be more controlling in relation to socialisation than mothers of undiagnosed individuals. Similarly, Rapee and Spence (2004) as well as Rubin, Coplan, and Bowker (2009) emphasised that parental overprotection, intrusiveness, and control relate to social withdrawal. This may be due to the fact that this type of controlling parenting style may limit the child's opportunities for independence, social skills development, and social exploration, which in turn contribute to SAD and a deprived sense of self-efficacy in social situations (e.g., Mills & Rubin, 1998; Murray, Cooper, Creswell, Schofield, & Sack, 2007). However, this association is not necessarily unique to SAD, as critical parenting styles have generally been related to anxiety disorders in children (e.g., Barrett, Duffy, Dadds, & Rapee, 2001a; Hirshfield, Biederman, Brody, 1997; McLeod, Wood, Weisz, 2007).



Moreover, Bögels and colleagues (2001) found that parental rejection, overprotection, and warmth in a socially anxious sample of 8-18 year old children were not specific to SAD versus psychopathology in general. On the contrary, Festa and Ginsburg (2011) showed, children's self-reported SA to be related to their perceived parental overprotection and not rejection. The difference in findings with respect to child-reported overprotection may be due to the nature of the samples (non-clinical vs. clinical). Furthermore, a study by Rapee and Melville's (1997) found mothers of children with panic disorder to be less controlling regarding socialisation than mothers of children with SAD. As a result, the aspect of controlling parenting, in particular towards social situations, is thought to play a crucial role in the development of SAD, yet, it remains unclear whether this parenting style is the cause of difficulties experienced in individuals diagnosed with SAD or whether the child's withdrawn behaviour elicits this maladaptive form of parenting. After all, there is a reciprocal relationship to this, as research has suggested that children's behaviour may influence parenting practices as well (Moore, Whaley & Sigman, 2004; Silverman, Kurtines, Jaccard, & Pina, 2009). Research that has looked into this matter supports the notion that a child's anxiety evokes distinct parenting behaviours, such as over protectiveness (Moore et al., 2004). Additionally, Rubin, Nelson, Hastings, and Asendorpf (1999) suggested that the way in which parents perceive their child's social caution and introversion had an impact on their inclination for socialisation techniques that restricted opportunities for the child to develop independence. Hence, indications exist that the relationship between parental style and the development of SAD in children is interactional. Results by Lieb and colleagues (2000) revealed that parental overprotection and

rejection were associated with SAD in their children, whilst family functioning was not. However, findings by Bögels and colleagues (2001) show only little support for the relationship between parental styles and SAD. Solely, family sociability and the child's perception of overprotection of the mother were found to predict SAD. As a result, the authors concluded that other untapped family rearing practices could be involved in the aetiology of SAD, considering only the child's perception had been interpreted.

This is in line with research that has found SAD to be associated with observational learning and parental psychosocial education processes (e.g., Beidel & Turner, 1998; Gerull & Rapee, 2002; Ollendick & Benoit's, 2012). These studies support the notion that observing or hearing about socially negative experiences may increase the risk of developing SAD. As a result, parental behaviour and expressions have a substantial impact on SAD, calling for research to investigate this further and to include parents in intervention programmes and related research. Moreover, the mental health of parents is undoubtedly another contributing factor in the development and maintenance of SAD (e.g., Egger & Angold, 2006; Lieb et al., 2000).

### *2.7.1 Parental Psychopathology*

Research has shown that children of anxious parents have an increased risk of developing an anxiety disorder (Beidel & Turner, 1997; Lieb et al., 2000; Merikangas, Dierker, & Szatmari, 1998), though the underlying mechanisms of transmission are still not fully understood (Bögels & Brechman-Toussaint, 2006). According to Sparrevohn and Rapee (2009), adults with SAD usually display less emotional expression and affection in close interpersonal

relationships compared to individuals without SAD. Likewise, socially anxious individuals are more self-critical and suffer from negative interpretation bias when compared with individuals diagnosed with other anxiety disorders (Amin, Foa, & Coles, 1998; Cox, Fleet, & Stein, 2004). These characteristics have been proposed to have an effect on parenting behaviours, such as less warm expressions towards their children and more critical interpretations of their child's behaviour and performance (Crosby et al., 2012).

Generally, anxious parents, particularly mothers, have been found to promote anxiety in their offspring by displaying more anxiety to their children, which increases the likelihood of later anxious responses in their children (Cooper et al., 2007; Rapee et al., 2009b). Accordingly, Lieb and colleagues (2000) demonstrated, in a longitudinal study with 1047 adolescents, a strong relationship between parental SAD and SAD in their children. The authors further showed that other psychological disorders such as alcohol abuse, depression, and other anxiety disorders were associated with SAD in their children. These studies suggest that parents' psychopathology plays a partial role in the development of SAD and that anxiety promoting parenting behaviours may depend on the psychopathology of parents. According to Connell and Goodman (2002), these factors are critical from both mothers and fathers. Correspondingly, Bögels and Phares (2008) summarised the evidence from cross-sectional and longitudinal research in infancy, childhood, and adolescence over the last few years and highlighted the crucial role that fathers play in child development.

### *2.7.2 Family Relations*

Following chapter 2.7, parent–child interactions and parenting styles indicate further factors that could play a significant role in the development and maintenance of SAD (e.g., Hudson & Rapee, 2001; Ollendick & Horsch, 2007; Rapee, 2001; Russel et al., 1998). This is due to the vast amount of learning that takes place within the home, since such socially isolating behavioural patterns manifest in some children as early as nursery (Hinde, Easton, Meller, & Tamplin, 1983). The frequency and intensity of negative feedback reinforces the belief that the environment is threatening and intimidating, also leading to biased perceptions in children and increased expectancy of negative outcomes and reduced self-competence (Krohne, 1992; Krohne & Hock, 1991; Wood, McLeod, Sigman, Hwang, & Chu, 2003).

In general, negative parent-child interactions may lead to the manipulation of social situations and decreased social skills (Masia & Morris, 1998). Furthermore, adults with SAD display less non-verbal and pro-social behaviours during interactions (e.g., eye contact and facial expressions) as opposed to non-socially anxious individuals (Baker & Edelmann, 2002). Consequently, these behaviours appear to present a risk factor for the development of SAD in children (Masia & Morris, 1998). As discussed in 2.7, negative rearing environments in general have been found to have an impact on anxiety levels in children based on the impact they have on children's views and beliefs (Bell-Dolan, Foster, & Smith, 1995; McLeod et al., 2007), while warmth and responsiveness are related to more socially adaptive behaviour in children (Hane et al., 2008). The social-learning theory (Breinholst, Esbjørn, Reinholdt-Dunne, Stallard, 2011), which proposes that children who observe anxious

communication and mannerisms from their parents usually model this behaviour, therefore, presents another environmental risk factor. Moreover, the way in which parents act in anxiety provoking situations, and the directions they provide their child with may lead the child to believe that a situation is unfeasible or dangerous and, hence, has to be avoided (Bögels & Brechman-Toussaint, 2006; Lester, Field, Oliver, & Cartwright-Hatton, 2009; Rapee, 2001). In line with this, findings have shown that parents who encourage avoidance usually have anxious rather than non-anxious children (Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004; Rapee, 2001). This, in turn, can have a serious deterring impact on developing useful and better suited coping strategies. In consequence, it is essential to include coping strategies in training programmes to account for this and to enhance these findings in terms of SAD.

Additionally, the element of social learning may be present with participants describing their parents as shy (Ishiyama, 1985), particularly if their own shyness began in childhood (Alden & Cappe, 1988). However, most of these studies have relied on self-report measures, which raise the question of memory accuracy and social desirability bias (Edwards, 1953), calling for more in-depth measures and analysis such as verbal interviews that consider individuals' own accounts of their experiences, reducing the opportunity to respond in a socially desirable way. Furthermore, studies have shown that insecure attachment bonds have negative effects on peer status (LaFreniere, & Sroufe, 1985) and the quality of friendships (Kerns, Klepac, & Cole, 1996; Lieberman, Doyle, & Markiewicz, 1999), which in turn can heighten the risk of developing and maintaining SAD. In consequence, the developmental impact on a child's peer interactions and their interpersonal difficulties are related to

negative and socially restrictive parenting attitudes reported by individuals affected by SAD.

### *2.7.3 Peer Relations*

Generally, the lack of social competence and deficiency in friendships is suggested to play a significant role in the development of SAD in children (aged 7-13 years) and in their negative experiences of social situations in school (Scharfstein, Alfano, Beidel, & Wong, 2011; Beidel et al., 1999b). These factors derive from the young children's difficulty and distress in working or playing with others, starting or joining in a conversation and talking to the popular children. Teachers' and parents' reports as well as self-reporting measures have also revealed more solitary break times and higher levels of depression when compared with controls (e.g., Booth-LaForce, Oxford, 2008; Oh, Rubin, Bowker, Booth-LaForce, Rose-Krasnor, Laursen, 2008). These findings connect SAD to aspects of peer relations that have long been of concern in non-clinical peer relationship studies. The unassertiveness and isolation in children diagnosed with SAD proposes the presence of a particular type of social withdrawal referred to in the peer literature as passive-anxious withdrawal (Rubin, Daniels-Beirness, & Bream, 1984; Rubin, Hymel, & Mills, 1989). To other children this behaviour is rather unusual which may lead them to reject these children, as they think they are different from them (Asher & Wheeler, 1985).

In fact, the study by Miers and colleagues (2010) demonstrated that unacquainted same age peers perceived adolescents with high levels of SAD as less socially skilled in comparison to low socially anxious equivalents during a speech task. This was on the content of their speech, their posture and body

movement, facial expression, as well as their way of speaking. This finding may explain why children diagnosed with SAD usually obtain undesirable reactions and feedback from peers in established relationships (Blöte, Kint & Westenberg, 2007; Spence et al. 1999) as well as why those individuals are less popular with new peers (Verduin & Kendall, 2008). Research investigating the negative effects of SAD on an individuals' performance, and including performance tasks as a form of exposure therapy, may not only help individuals to overcome their fear of performance but may also shed more light on these destructive effects. Furthermore, it can support previous findings on cognitive biases with regard to their self-perception.

These findings coupled with the fact that high quality friendships appear to act as a protective factor against many negative consequences deriving from shyness, behavioural inhibition, and poor self-esteem (Coplan, Arbeau, & Armer, 2008; Gazelle & Ladd, 2003; Rubin, Dwyer, Booth-LaForce, Kim, & Rose-Krasnor, 2004), highlight the importance of teaching communicative competence and social skills to children from an early age. Nonetheless, it is important to keep in mind that research over the years has shown that peer relations and parenting alone are not a risk factor compared with other environmental factors (Brook & Schmidt, 2008).

## *2.8 Treatment of SAD (Cognitive Behavioural Therapy)*

Numerous treatments for SAD have shown to be effective over the past years, including cognitive therapy, CBT, behavioural activation therapy, relaxation training, pharmacotherapy and social skills training, to name a few (e.g., Beidel & Turner, 1998; Heimberg & Juster, 1995; Hopko, Robertson, & Lejuez, 2006). Despite significant success rates of different treatments, CBT is known to be the most effective and often the first-choice treatment for SAD due to particularly high response rates (e.g., Khanna & Kendall, 2009; Hofmann, 2010; Rapee et al., 2009a). Considering the paramount role cognitive factors play in the development and maintenance of SAD in contrast to other anxiety disorders, treatments that focus on the restructuring of distorted thoughts and fears, which appear to be at the root of SAD, emerge to be most effective (Ahrens-Eipper & Leplow, 2004; Heimberg & Juster, 1995; Stangier, Schramm, Heidenreich, Berger, & Clark, 2011; Tuschen-Caffier et al., 2009). The main classes of CBT that have been applied to the treatment of SAD successfully are exposure, cognitive restructuring, relaxation training, and social skills training. Hence, for the purpose of the current research, this thesis will focus on CBT in combination with the training components discussed below.

### *2.8.1 Definition of CBT*

CBT is a time-limited and present-orientated, evidence-based psychological approach, that is practiced by professionals for treating mental health, personal and family difficulties (Sheldon, 2011). Its focus is on the cognitive and behavioural abilities required to function in a person's intra- and interpersonal world (Heimberg, 2002). During CBT, the patient and therapist try to address the



patient's worries together in a step-wise method. CBT is based on a talking cure that intends to solve problems concerning dysfunctional emotions, cognitions, and behaviours through a goal-orientated, systematic procedure. Thus, the focus on a programme based on CBT would not only help to control negative emotions (e.g., fear), it may further enhance the emotional awareness of oneself in conjunction with others. A core component of CBT for childhood anxiety is a focus on modifying maladaptive thinking (e.g., Kendall 2011). Minde, Roy, Bezonsky, and Hashemi (2010) found that a slightly modified form of CBT including the active involvement of parents is a useful tool in the treatment of anxiety disorders in early school as well as preschool aged children. This is in line with earlier findings by Beidel, Turner, and Morris (2000), who looked into a multifaceted behavioural treatment of childhood SAD and found significant improvements among others in social phobic fear. The following will present the main classes that have been applied for SAD.

### *2.8.2 Exposure*

Exposure practises are designed to support patients to face their feared situations, while remaining psychologically engaged to enable the natural conditioning processes involved in fear reduction to occur (e.g., Beidel & Turner, 1998, Gallagher, Rabian, & McCloskey, 2004; Heimberg, 2002, Minde et al., 2010). To begin with, the patient and therapist identify the anxiety-provoking situations in a rank-ordered list to start working on the least feared situation followed by more severely feared situations as a systematic approach. This is completed through role-play, an imaginative approach (whereby the therapist describes scenes for the patient to imagine), or by confronting feared situations outside of

sessions. Usually a combination of all three is applied and the patient is required to absorb the situation until the anxiety naturally begins to decrease.

Heimberg (2002) states exposure to be the central component of most variations of CBT for anxiety. According to Foa and Kozak (1986), for the exposure technique to be fully effective the patient is required to engage entirely with the feared situation, even to the extent of experiencing the anxiety and for negative stimulation to occur. However, this may present a difficulty for the patient and instead they may engage in well-intentioned but maladaptive efforts to manage their anxiety experience by distracting themselves and absorbing the details of the feared situation. Generally, the distracting thoughts will be more occupied with their self-perception in the situation of danger rather than with what is truly occurring around them (Heimberg, 2002). Nevertheless, Wells and Papageorgiou (1998) observed that instructions to sustain ones focus on the anxiety-provoking situation increases the effectiveness of exposure techniques. However, further components are necessary for successful results.

### *2.8.3 Cognitive Restructuring*

A vast amount of research underlines that the patient's effort to examine their thoughts about feared situations, and the beliefs that may underlie them, plays an important role in reducing their anxiety (Heimberg, 2002; Kendall & Hedtke, 2006, McNally Keehn, Lincoln, Brown, & Chavira, 2013). This is in line with cognitive behavioural models of SAD as discussed previously. These note that fear arises through inaccurate beliefs about the possible threats in social situations, creating negative expectations about the consequences of these

situations, and biased processing of certain events that emerge during social situations (Clark & Wells 1995; Rapee & Heimberg 1997).

Heimberg (2002) explains the arrangement of cognitive restructuring, where patients are taught to firstly identify negative thoughts that arise prior, during, or subsequent to feared situations, secondly to assess the accuracy of these beliefs in the light of challenging these thoughts, and lastly to develop rational alternative thoughts based on the acquired information. Although this technique includes components of exposure, the focus of exposure in this setting is on the assembly of acquired information that will enable patients to review their judgments about the actual degree of risk to which they are exposed in feared situations. Behavioural experiments may include trying to face anxiety-provoking situations without engaging in “safety behaviours” (Clark & Wells, 1995). These behaviours are actions that patients mistakenly trust to enable them to cope with their fear effectively. However, they seem unaware that these actions prevent them from realising they might have succeeded in those situations without these behaviours (Wells et al., 1995). Hence, further techniques are required to assist individuals in dealing with feared scenarios.

#### *2.8.4 Relaxation Training*

Most approaches to relaxation training derived from studies by Wolpe (1958), and Bernstein and Borkovec (1973). Generally, the techniques applied in relaxation training are designed to assist patients to focus and manage the level of physiological responses experienced during or in anticipation of feared events. Patients are therefore asked to relax and tense their muscles in a methodical manner in order to attain maximal relaxation and notice the difference between

tension and relaxation. Authors found that anxiety, perceived stress levels and resulting levels of high blood pressure and heart rates decreased through progressive muscle relaxation (PMR; e.g., Pawlow & Jones, 2002; Rausch, Gramling, & Auerbach, 2006; Sheu, Irvin, Lin, Mar, 2003), supporting its benefits.

There is a strategic way of focussing on different muscle groups at a time and then for patients to learn to examine their body for muscle tension and work on it by remembering how those muscles felt when relaxed. Considering SAD, relaxation training is only effective when applied together with exposure. Here patients first learn to attend to the physiological feelings of anxiety. This is followed by learning to relax in everyday activities and then, applying relaxation techniques in feared situations (Rodebaugh, Holaway, Heimberg, 2004; Öst, 1987). It is noteworthy that most of these studies have been conducted on adults (with a few exceptions; e.g., Köhl et al., 2010; McNally Keehn et al., 2013) and it would therefore be interesting to apply such training to children. Furthermore, the education of other relevant skills seems crucial in the treatment/prevention of SAD.

#### *2.8.5 Social Skills Training*

Generally the treatment of SAD aims to reduce the distress linked with the anxiety and to increase the levels of social functioning in an individual (Andrews et al., 2003; Spence et al., 1999, 2000). The cognitive and behavioural strategies applied intend to provide the socially anxious person with different strategies to function better and with less distress in social settings (Heimberg, 2002). Social Skills Training usually includes behavioural rehearsal, corrective feedback,

social reinforcements, and therapist modelling (e.g., role-plays, etc.). It has been found to lead to improvements due to the training aspects, such as the repeated practice of anxiety-provoking social behaviours (Heimberg, 2002). This is in line with studies that implemented social skills enhancement strategies in their programmes and found a reduction in levels of SAD, highlighting the benefits of social skills and interpersonal competence in the treatment of SAD (e.g., Maag, 2005; Michalski, Mishna, Worthington, & Cummings, 2003). However, the social skills training alone, is not effective for improving social skills (Ponniah & Hollon, 2008). Nevertheless, the combination of this training component with others, particularly exposure therapy, could be (e.g., Beidel et al., 2014; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014).

Universal school-based programmes, that support social and emotional learning in pupils, have demonstrated an enhancement in children's success in both school and life domains (Elias et al., 1997; Zins & Elias, 2006). However, the possibility that individuals diagnosed with SAD do not necessarily lack social skills, but rather, show an inhibition in such skills should not be disregarded (Heimberg & Juster, 1995). Heimberg and Juster (1995) raised the issue that social skill deficits are secondary to poor social behaviour rather than defined by it, because inadequate social behaviour can arise for various other reasons. In particular, social skills training for SAD is based on research concluding that individuals diagnosed with SAD exhibit behavioural deficiencies, such as poor eye contact or deprived conversation skills, that cause negative reactions from others, and in turn trigger social interactions to be perceived as humiliating and anxiety provoking (e.g., Goodwin, Fergusson, & Horwood, 2004; Beidel et al., cited in Essau & Ollendick, 2013; Heimberg et al.,

1995). However, it is unclear whether these behavioural deficits are a function of social knowledge, social skills, behavioural inhibition, avoidance produced by anxiety, or a combination of all these factors. While some studies suggest the occurrence of performance deficits (Halford & Foddy 1982), others have failed to support these findings (Glasgow & Arkowitz, 1975), although more research over the years support the notion that individuals with SAD underestimate the competency of their behavioural performance, which may lead to actual performance deficits (Rapee & Lim 1992; Stopa & Clark 1993).

Whilst early research suggested that SAD, and the problems of functioning in social situations deriving from it, arise from a lack of interpersonal skills (Heimberg, 1989), many subsequent studies have not supported this notion and instead suggest that individuals with SAD often perceive their social behaviour as inadequate (Stopa & Clark, 1993). As social skills training aims to teach effective social behaviour, this component is appropriate. The study by Turner, Beidel, Cooley, and Woody (1994) supported the effectiveness of this approach, through exposure to feared stimuli in undertakings, such as group training and homework, that require children to participate in social activities, and may therefore enhance these benefits. In contrast, Stravynski and colleagues (2000) looked into whether or not including social skills training would make a difference in their participants. Both groups of participants revealed reduced anxiety symptoms at post-programme and 1-year follow up. This indicates that the combination of various successful training components is what aids the benefits of a treatment programme. Similarly, Bögels and Voncken (2008) compared social skills training and cognitive therapy in SAD patients with fear of blushing, trembling, and sweating through measures taken at pre-treatment,

mid-treatment, post-treatment, 1-month, and 1-year follow-up. Their findings showed that both treatment approaches were successful in the short- as well as the long-term, with large effect sizes. Although these results are limited to self-report measures and no wait-list or control group condition, the exposure aspects, such as challenging the feared situation, or the cognitive elements of beneficial feedback, when combined with social skills training, helps the enhancement of social abilities. In fact, social skills training is commonly combined with other techniques such as cognitive restructuring or exposure (Beidel et al., 2014; Turner et al., 1994) and as a result could increase treatment outcomes in individuals diagnosed with SAD as well as possibly be preventative of developing this disorder in the first place. It may be concluded that the combination of social skills training with CBT-based components may enhance treatment and prevention programmes for SAD and therefore is essential (Beidel et al., 2014; Heimberg, 2002).

#### *2.8.6 Critical Evaluation of Past Studies Implementing CBT*

The combination of CBT and psychopharmacological therapy have demonstrated efficacy in the treatment of SAD, although CBT has been shown to have more long-lasting positive effects (e.g., Clark et al., 2003; Hitchcock et al., 2009). However, most interventions derived from CBT are aimed at adults (e.g., Rapee, 2000; Turner, Beidel, & Cooley-Quilly, 1997), leaving room for improvement by exploring further how CBT can help particularly socially anxious children and what components are best (McManus, Peerbhoy, Larkin, & Clark, 2010). Table 2.2 summarises a number of studies that targeted anxiety disorders and SAD with children and adolescent samples. Despite some crucial differences, most of these

programmes have the following components in common: psycho-education, exposure, anxiety coping skills (such as problem-solving, cognitive restructuring, and relaxation techniques), and homework assignments in order to enable the facilitation of acquired skills in real-world situations.

Significant findings of the randomised clinical trial by Kendall (1994), for example, on the “Coping Cat program (Cat)”, a child behaviour therapy programme (Flannery-Schroeder & Kendall, 2000; Kendall, 1990, 1994; Kendall & Hedtke, 2006) indicated a significant decrease in levels of general anxiety and improved coping behaviour, supporting the efficacy of CBT in the treatment of anxiety disorders in children and adolescents. These typically included a combination of challenging negative thoughts and behavioural exposure (e.g., Kendall, 2011). A recent study that tried to improve the efficacy of the CAT and enhance treatment dissemination was by Crawley and colleagues (2012) who focussed on a briefer and more exposure task directed version. Their findings also revealed significant results regarding the reduction of anxiety symptoms; yet, the fact that the authors did not employ a comparison condition limits their findings. A more recent study by Essau and colleagues (2014) examined the effectiveness of Super Skills for Life, a transdiagnostic prevention programme in children that were known by their teachers to present severe anxiety problems. Their findings showed reduced levels of anxiety symptoms at post- and follow-up assessment. This is in accordance with previous research that tested CBT in anxious children (e.g. Barrett et al., 1996b; Cobham, Dadds, & Spence, 1999; Kendall et al., 1997; Silverman, Kurtines, Ginsburg, Weems, 1999). Furthermore, though the follow-up studies of the CBT-based studies for anxious children demonstrated the maintenance of these effects at a mean age of 3.5



(Kendall & Southam-Gerow, 1996), 6 (Barrett et al., 2001a) and 7.4 (Kendall et al., 2004) they should be considered in the light of their limitations. The administration of, for example, multiple analysis of variance (MANOVA) or hierarchical multiple regression analysis (HRA), are both methods not ideal for accounting for missing data at key time points and, thus, could have jeopardised the general application of the findings. Notwithstanding the development of HRA over the years with regard to missing data, other analyses still remain more suitable. In addition, despite the positive findings in anxiety reductions in the presented studies, it is crucial to keep in mind that these findings refer to anxiety in children and are not specific to SAD.

One of the earlier studies that showed treatment results specific to SAD in adolescents is the study by Albano, Marten, Holt, Heimberg, and Barlow (1995). The authors examined the efficacy of a 16-week group CBT for five adolescents affected by SAD. All participants except one were free of diagnosis at 3-months post-treatment, and at 1-year follow-up. Their findings however, are limited to a very small and solely clinical sample. In a more detailed study by Spence, Donovan, and Brechman-Toussaint (2000) children with a primary diagnosis of SAD were divided into control group, intervention group including parent involvement, and treatment group without parental involvement. The intervention group was based on CBT including social skills training, cognitive restructuring, and exposure therapy. In contrast to the control group, both treatment groups demonstrated improvements in SAD and generalised anxiety and these results were maintained at 12-month follow-up. However, a significant proportion of participants failed to respond to the intervention, especially in the absence of parental involvement.

In addition, these findings were restricted to children with SAD. Thus, it remains unclear how well a heterogeneous sample of children with SAD respond to a CBT-based approach that emphasised social skill strategy as in the study by Spence and colleagues (2000) rather than the CBT approach of Kendell (1994). Hence, despite the successful treatment outcomes, other strategies with greater efforts directed at recognising and preventing SAD in children are necessary to facilitate identification and to prevent the harmful consequences of SAD (Hitchcock et al., 2009). Furthermore, the majority of past studies on the treatment of SAD did not include specific measures for SAD, thus future studies should address childhood SAD in particular (Hitchcock et al., 2009). According to the study by Hudson and colleagues (2010) children with a primary diagnosis of SAD showed poorer treatment outcomes than those where SAD was not the primary diagnosis, which indicates a better remission for anxiety disorders in general.

In 1998, Beidel and colleagues developed a multifaceted behavioural treatment model (Social Effectiveness Therapy for Children; SET-C) based on a successful programme for adult SAD by Turner and colleagues (1997). The SET-C includes social skills training, in vivo exposure, and child and parent education, aiming to reduce levels of SAD and enhance social skills. Their findings demonstrated improvements in children's SAD, social skills, and overall social competence. According to Beidel and colleagues (1999a), and in line with what has previously been recognised, children with SAD suffer from social skill deficits, emphasising the importance of addressing these deficits in treatment programmes. Later findings by Beidel and colleagues (1999b) on 'Testbusters', a programme designed for pupils teaching study skills among others, further

showed a reduction in children's levels of test anxiety, increased social skills, and increased engagement in social conversations, as well as reduced avoidance. Furthermore, these effects were maintained at 6-month follow-up across ethnicity, gender, and age. In spite of the authors' significant findings, one of the limitations was that the comparison with a wait-list condition was not reported, leaving the within-treatment differences to be superior to no treatment rather vague.

In a more recent study by Kerns, Read, Klugman, and Kendall (2013) these limitations were addressed. Their findings proposed children with SAD to report higher levels of anxiety prior to and after 16-weeks of CBT contrary to youth without SAD. In addition, children with SAD responded less favourably from pre-treatment to 7.4-year follow-up compared to children without SAD. This suggests that CBT, without explicit focus on social skills, is equally effective for children with and without SAD in the short term but not long-term. However, positive treatment gains were reported up to three years following the SET-C, contrasting these findings (Beidel, Turner, Young & Paulson, 2005). As a result, future research should look into the mechanisms underlying the increased levels of SAD and poorer long-term outcomes of children with SAD and elaborate whether modifications to CBT programmes may benefit children more. As it stands, medium to large improvements in outcomes have been found in studies comparing CBT interventions with wait-list, experimental, and inactive controls (Compton et al., 2004).

A more recent study by McEvoy, Nathan, Rapee, and Campbell (2012) emphasised the success of Cognitive-Behavioural Group Therapy (CBGT) by

looking into a research and community sample. Their results showed a significant reduction of SAD at post-treatment in both samples, emphasising the transferability of CBGT to community settings. However, the different follow-up periods did not permit comparisons across treatment settings, preventing the authors from determining whether the gains at post-treatment were maintained, or not, across treatment settings over time. Lastly, the limitation of the outcome to self-report measures leaves it unclear how the evaluated scores related to actual behavioural change. Similarly, the earlier study by Gallagher and colleagues (2004), which looked into the effects of their CBGT intervention developed for preadolescents with SAD, showed significant reductions in levels of SAD in children based on self-report measures. Their programme was delivered over the course of three weeks in three intensive group sessions and included cognitive exercises, behavioural exposure, and psycho-education. Significant results were noted at 3-week follow-up rather than immediately after the intervention, which may have been due to the children applying and improving some of the skills learned during the programme in the weeks following the completion of the treatment. However, the authors' limitation purely to children's self-report measures and no assessments of parents or teachers, as well as their constraint to a clinical sample, limit the generalizability of their findings.

The early onset of SAD underlines the necessity of early intervention as well as prevention (Beidel et al., 2000). While interventions usually begin once the individual has been diagnosed, prevention programmes occur before disorders have developed to enhance protective factors or reduce risk factors of developing disorders (Costello, Mustillo, Erkanli, Keeler, Angold, 2003; Essau et

al., 1999, Kendall, Warman, 1996). This, in the light of the severity of SAD, enhances the necessity of successful implementation of such programmes. The effectiveness of prevention programmes involving parents has been inconsistent thus far. In particular, literature looking into child focussed and family CBT (e.g., Barrett et al., 1996a; Cobham et al., 1999) were rather inconsistent in their findings. While some studies demonstrated a positive and more beneficial effect of parents being involved (Barrett et al., 1996a; Cobham et al., 1999; Essau et al., 2012; Wood, Piacentini, Southam-Gerow, Chu, Sigman, 2006) other studies failed to produce such findings (Barrett, 1998; Nauta, Scholing, Emmelkamp, & Minderaa 2003; Spence et al., 2000). It is therefore still to be investigated where the differences lie in appraising the most beneficial approach for children (cf. Essau et al., 2012).

Table 2.2: Summary of Additional Relevant Findings of Past Studies Employing CBT

<i>Authors</i>	<i>Type of programme</i>	<i>Designed for</i>	<i>Sample</i>	<i>Findings</i>	<i>Limitations</i>
Ahrens-Eipper & Leplow (2004)	CBT	SAD	93 clinical	Significantly greater reduction of social insecurity, increase of self-esteem and social skills compared to CG.	Clinical sample
Muris, Meesters, & Melick (2002)	CBGT	SAD	30 clinical	Reductions of levels of anxiety, trait anxiety, and depression after treatment as opposed to the WLC.	Small sample size Clinical sample Limited to child self-reports  No post-treatments assessment of diagnostic criteria for anxiety disorders and no follow-up assessment included

Table 2.2: Summary of Additional Relevant Findings of Past Studies Employing CBT

<i>Authors</i>	<i>Type of programme</i>	<i>Designed for</i>	<i>Sample</i>	<i>Findings</i>	<i>Limitations</i>
Baer & Garland (2005)	School-based modified social effectiveness  CBGT	SAD	12 clinical	Significantly greater improvement in both examiner-evaluated and self-reported measures on SAD as opposed to CG.	Clinical sample  Small sample size
Masia, Klein, Storch, & Corda (2001)	School-based behavioural treatment programme, 14-session  (Skills for Academic and Social Success)	SAD	6 clinical	All participants responded distinctly or moderately to the treatment. At post treatment, 3 of 6 participants were diagnose free of SAD. All measures of SAD demonstrated a significant decrease after intervention except the SPAI-C.	Clinical sample  Small sample size  No decrease on SPAI-C (valid SA measure)

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<i>Authors</i>	<i>Type of programme</i>	<i>Designed for</i>	<i>Sample</i>	<i>Findings</i>	<i>Limitations</i>
Silverman et al. (1999)	CBGT	Anxiety disorders	56 Clinical sample	Concurrent parent sessions in CBGT, were highly efficacious in producing and maintaining treatment gains. Children improved extensively on all main outcome measures and these findings were maintained at 3-, 6-, and 12-month FU.	Clinical sample  Focus on anxiety disorders in general
Donovan & March (2014)	Online CBT	Anxiety disorders	52 Clinical sample	Internet-based therapist assisted, parent-focused CBT-Programme for children resulted in significant symptom reduction of anxiety and internalising behaviour. Findings were maintained at 6-month FU.	Clinical sample  No face-to-face interaction with therapist  Focus on anxiety disorders in general



Table 2.2: Summary of Additional Relevant Findings of Past Studies Employing CBT

<i>Authors</i>	<i>Type of programme</i>	<i>Designed for</i>	<i>Sample</i>	<i>Findings</i>	<i>Limitations</i>
Shortt, Barrett, & Fox (2001)	A family-based CBGT (FRIENDS)	Anxiety disorders	71 clinical	69% of children who completed the programme no longer fulfilled diagnostic criteria, compared to 6% of children of the WLC. At 12- month follow-up, 68% of children were diagnosis-free.	Diagnostic interviews with parents only  No measures of symptoms or functioning apart from anxiety were employed
Crawley et al. (2012)	8-Session CBGT (Coping CAT)	Anxiety disorders	26 clinical	42.3% of youth were diagnose-free of their principle anxiety diagnosis at post-treatment. 33.3% of youth maintained these gains at a 2-month follow-up. This increased to 65.0% at 1-year follow-up, though 55% of participants were seeking additional treatment.	No comparison condition  Participants were free to seek additional treatment between 2-month and 1-year follow-up, which limits successful findings being due to the CBGT.

					Limited to anxiety disorders in general
					Small sample size
					Clinical sample
Collins, Woolfson, & Durkin, K. (2013).	Universal school-based intervention	Anxiety Disorders	317 randomised sample	Self-reported anxiety significantly reduced at post-treatment as well as the use of avoidance coping skills, while problem-solving coping skills increased, for the intervention group compared to the comparison group. These results were maintained at six-month follow-up.	Limited to anxiety disorders in general and level of coping

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Notes: SAD=Social Anxiety Disorder; SPAI-C= Social Phobia and Anxiety Inventory for Children, CBGT= Cognitive Behavioural Group Therapy; WLC=Wait-list Condition

Critical evaluation of the studies outlined in Table 2.2 demonstrates a substantial amount of CBT-based programmes to have shown to be effective in the treatment of anxiety, specifically SAD. Nevertheless, the findings must be interpreted with caution due to their limitations. To summarise, the presented studies are restricted to clinical samples, small samples, self-report measures of either children or parents, and the lack of follow-up measures, or their focus on anxiety disorders in general instead of SAD. In addition, research has shown that not all individuals with SAD achieve optimum response with standard CBT packages (e.g., Compton et al., 2014). Thus, improvements are necessary.

Furthermore, the number of children who are actually receiving treatment is rather low. Essau (2005) reported that less than 20% of children and adolescents who require mental health services actually receive such services. This may be due to the stigma attached to receiving psychological treatment (Wagner, Silove, Marnane, & Rouen, 2006) along with the cost and time involved, accessibility, and the location, particularly for families living in suburban or rural areas (Barrett & Pahl, 2006). According to Weist (1999), children are not necessarily identified for needing any treatment, waiting lists are long, and the dropout rates sometimes exceed 50%. Anxiety disorders, SAD in particular, often go unnoticed due to unrecognised or misdiagnosed symptoms or teachers and parents generally assuming the normality of being shy at a certain age (Albano, Chorpita, & Barlow, 2003). Consequently, it is important to develop and support intervention and prevention programmes that are more accessible (e.g., in schools) to individuals with elevated symptoms of anxiety disorders or to individuals with a high risk of developing such disorders. Moreover,

the high prevalence in children and adolescents (Cartwright-Hatton, McNicol, & Doubleday, 2006; Hayward, Killen, Kraemer, Taylor, 1998; Stein et al., 2001; Wittchen et al., 1999) and the dramatic social and personal inhibitions experienced, that are associated with these disorders (e.g., Ollendick, 2009; Saavedra et al., 2010; Wittchen, Fuetsch, Sonntag, Müller, Liebowitz, 2000) emphasise the importance of early intervention programmes to prevent or inhibit the development of SAD in individuals as early as possible.

In spite of the limitations of the CBT-based studies and the empirical evidence suggesting only half to two-thirds of children benefitting from significant symptom reduction or recovery at post-treatment (Olatunji, Cisler, & Tolin, 2010; Silverman, Pina, & Viswesvaran, 2008), CBT remains the preferred method of treatment for anxiety disorders in children and adolescents based on the enormous evidence-based research available (In-Albon & Schneider, 2007; Essau et al., 2014; Kley, Heinrichs, Bender, & Tuschen-Caffier, 2012; Seligman & Ollendick, 2011). These studies, however, may suggest CBT to be more beneficial to children and adolescents with anxiety disorders other than SAD (e.g., Crawley et al., 2008). In line with the specified studies, the review of meta-analytic research by Hofmann, Asnaani, Vonk, Sawyer, and Fang (2012a) presents a strong evidence-base for CBT, particularly in the treatment of anxiety disorders. However, some inconsistencies regarding the long term efficacy of CBT treatments (e.g., Olatunji et al., 2010; Silverman et al., 2008) highlight the importance of future research to continue building on existing knowledge in ways that will contribute to theoretical as well as

methodological advances in this field, thus leading to more consistent findings as well as the reduction of SAD in children.

According to available research, elevated levels of self-focused attention and self-consciousness play a significant part in the maintenance of SAD (Bögels & Mansell, 2004; Clark & Wells, 1995; George & Stopa, 2008). In adult studies, CBT significantly decreased self-focused attention and self-focused thoughts, which were related to lower levels of SAD at post-treatment (Hofmann, 2000; Woody, Chambless, & Glass, 1997). Nonetheless, studies investigating this relationship in children and adolescents are scarce, especially when it comes to their own experience of such demanding life situations. However, findings have shown a significant link between self-consciousness and SAD and negative affect in youth (Higa, Phillips, Chorpita & Daleiden, 2008; Hodson, McManus, Clark & Doll, 2008). Thus, self-consciousness in children is known to play a comparably important role in SAD as in adults, but it remains unclear whether the amount of self-awareness changes during treatment and whether or not these alterations, in turn, play a substantial part in predicting variations in SAD. Hence, despite existing research supporting CBT programmes as an effective intervention for SAD in children and adolescents (e.g., Kremberg, & Mitte, 2005), more research is required to improve treatments for children, particularly in a preventative fashion.

### *2.8.7 Prevention and Intervention Programmes*

Currently, there are three types of prevention and early intervention programmes that are usually offered in schools, each with advantages and disadvantages (Mrazek & Haggerty, 1994). Universal programmes are delivered to all pupils regardless of the existence of symptoms (Barrett & Turner, 2004), whilst selective programmes are targeted at children who are at risk of developing a disorder (Spence, 1996). Indicated programmes are delivered to children with early or mild symptoms of a disorder. Research has shown larger effects from indicated and selective programmes rather than universal interventions (Reivich, Gillham, Chaplin, & Seligman, 2005). This may be due to the greater scope for change in participants diagnosed with a disorder or at risk of developing one (Reivich et al., 2005). However, universal programmes reduce the level of stigmatisation due to their collective application and preventative nature.

Considering that prevention programmes are usually aimed at larger groups, teaching participants generic life skills applicable to everyday situations, they also support learning as well as healthy development within social settings (Barrett et al., 2001a). Likewise, prevention programmes may enable the identification of children at risk of a disorder (Fisak et al., 2011). Regardless of the potential and necessity of universal prevention programmes, however, such programmes are rather rare (Spence, 1994). One of the first universal prevention programmes that demonstrated efficacy is STEP by Felner and colleagues (1993) who conducted their programme in a school setting over a period of two years. Although no follow-up was conducted for this study the findings demonstrated reductions in anxiety and depressive

symptoms as well as improvements in anti-social behaviour. According to the World Health Organization (2004), one of the highest evidence-based prevention programmes to date, including successful follow-up assessments, is the FRIENDS programme for childhood anxiety.

FRIENDS is a CBT-based programme that emerged in Australia. Barrett and Turner (2001) were the first to examine the effectiveness of the programme. The authors delivered FRIENDS as part of the standard curriculum and children were assigned to the control group (no programme), teacher-led interventions, or psychologist-led interventions. In addition, parents were invited to participate in four parent sessions as part of the programme. The results showed a significant reduction of anxiety symptoms in both intervention groups as opposed to the control group, supporting the effectiveness of the FRIENDS programme for children, yet the findings were limited to the children's self-reports and the absence of multi-informant measures (e.g., parents' or teachers' report). The study by Lowry-Webster, Barrett, and Dadds (2001) however, which looked into a sample of nearly 600 children produced similar findings. The participants in the experimental group demonstrated fewer symptoms of anxiety and depression in contrast to the control group. In addition, 75% of children in the intervention group initially identified as at risk no longer presented the symptoms at post-intervention contrary to the control group where 42% of the children remained at risk. These effects were enhanced at 12-month follow-up (Lowry-Webster, Barrett, & Lock, 2003), when 85% of the children in the intervention group were diagnosed symptom free, unlike only 31% in the control group, which indicates the efficacy of the FRIENDS programme.

Interestingly the study by Lock and Barrett (2003) not only supported these findings but also established that the prevention effects of the programme were strongest for the younger children, when compared to the older participants in their sample of 9-10 year olds and 14-16 year olds, and seemed to be more beneficial to girls than boys. The study by Stallard and colleagues (2007) demonstrated similar findings with their sample of 9-10 year olds, using two standardized measures (Spence Children's Anxiety Scale, and the Culture-Free Self-Esteem Questionnaire) six months prior to the intervention, at start, and at three-month post-intervention to evaluate the FRIENDS programme. Their findings showed significantly lower levels of anxiety symptoms and higher levels of self-esteem at three-month follow-up, with children who had the most severe emotional problems benefiting the most. Whilst Mostert and Loxton (2008) could not find a significant decrease in anxiety symptoms at post-intervention, they demonstrated significant decreases at both follow-up points (4 and 6 months after the programme). These findings may be due to children acquiring and accomplishing the skills learned over time. Accordingly, Essau and colleagues (2012) found intervention group children to report lower levels of anxiety symptoms than children in the control group, although these findings were more significant at the 12-month follow-up. In addition, the authors found that children in the intervention group partially improved in coping skills more than children in the control group.

Thus, a programme focussing more on ER strategies may enhance the improvements on coping skills in children and, in turn, reduce their levels of anxiety. In contrast to Lock and Barrett (2003), Essau and colleagues (2012) did not find a



significant difference between boys and girls, suggesting that gender groups responded equally to the intervention programme. However, age was identified as a moderating factor of change; that is, younger children showed programme gains earlier than older children. Accordingly, an earlier intervention seems advisable due to the cognitive factors that may play a role in a child's development as well as the fact that children seem to be more receptive at a younger age.

The FRIENDS programme has also been validated cross-culturally, in South Africa (Mostert & Loxton, 2008), the United Kingdom (Stallard, Simpson, Anderson, Hibbert, & Osborne, 2007), and in Germany (Essau, Conradt, Sasagawa, & Ollendick, 2012). However, it should be noted that the FRIENDS programme has been focussed on anxiety and depression and is not generally applicable to SAD. Considering the high occurrence of SAD and related adverse effects (e.g., Kühl, Bender, Kley, Krämer, & Tuschen-Caffier, 2010), the need to prevent the onset of SAD is vital (Neil & Christensen, 2009) and programmes that are based on the successful aspects of the FRIENDS may be of advantage. However, there are few parents seeking treatment for their children, and of those who do, some end the treatment precipitately or the children fail to respond to the treatment (Brozovich & Heimberg, 2011; Donovan & Spence, 2000; Essau, 2005; Farrell & Barrett, 2007). According to Donovan and Spence (2000), the latter often arises when treatment is offered at a stage where SAD symptoms are already quite pronounced. Another factor for the low participation rate is the costs involved in treatments as they are beyond some families' budgets (Neil & Christensen, 2009). Hence, schools seem to be the most accessible environment for prevention and early intervention

programmes for anxiety (Masia-Warner, Nangle, & Hansen, 2006), particularly as school settings offer a low cost as well as natural environment.

School-based programmes delivered as part of the Personal, Social, Health and Economic Education (PSHE) curriculum or as an after school programme can not only reduce stigmatisation, time and travel issues, and cost, but also increase the advantages such programmes have for children (Barrett & Pahl, 2006; Masia-Warner et al., 2006). Moreover, schools are more likely to enable the acquisition of skills, as they are already perceived as places of learning (Rambaldo, Wilding, Goldman, McClure, & Friedberg, 2001). Both efficacy and effectiveness trials have been conducted in schools and, while the latter assesses an intervention under real life or naturalistic conditions, efficacy trials evaluate a programme under optimal and controlled conditions (Dane & Schneider, 1998; Flay et al., 2005). Measuring the utility of school-based programmes exclusively is of high importance, considering that schools are suitable settings for the implementation of prevention programmes (Neil & Christensen, 2009). Moreover, prevention and early intervention programmes may benefit from delivery in an ecologically valid context in which many feared situations occur (e.g., Mychailyszyn et al., 2011).

Neil and Christensen (2009) conducted a systematic review of school-based prevention and early intervention programmes for anxiety. Their results showed that overall these programmes have produced significant reductions in symptoms. Moreover, the significant effects obtained were independent of the type of intervention. In addition, research supporting the success of CBT in the treatment of anxiety disorders in children and adolescents highlight the importance of employing

CBT-based programmes (e.g., Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Compton et al., 2004).

Neil and Christensen (2009) summarised that programmes delivered by teachers demonstrated significant reductions in anxiety symptoms, supporting the notion that such prevention programmes can be successfully implemented in real-world environments and be delivered by viable programme leaders. Gillham and colleagues (2006) however, found effectiveness trials that involved classroom teachers to present smaller effects, which may be due to the less experienced nature of teachers regarding CBT than mental health professionals, graduates, and researchers. Therefore, training teachers to deliver programmes in the required way can enable them to deliver these more effectively and thus reduce levels of anxiety in primary school age children in a cost-effective way (Stallard, Simpson, Anderson, & Goddard, 2008).

Furthermore, testing long-term effects of intervention/prevention programmes is crucial, as it has been suggested that participants require time for preventative effects to arise and to adapt acquired skills (Gillham, Shatté, & Reivich 2001). This notion is supported by studies where no significant findings were detected immediately after the treatment but during the follow-up period (Barrett, Lock, & Farrell, 2005; Dadds et al., 1999; Gillham et al., 2006; Misfud & Rapee, 2005). Moreover, follow-up assessments and the examination of the overall duration of effects can avoid possible underestimations of the effectiveness of school-based programmes and further determine the most appropriate time for booster sessions (Gillham et al., 2001). Programmes such as FRIENDS and Skills for Academic and

Social Success (SASS; Fisher et al., 2004) include two boosters at one and three months after the completion of intervention and they seemed to have positive effects. However, the requirement and usefulness of the booster sessions is indistinct, as neither programme has been tested without them. This is similar to the effectiveness of programmes that involve parental engagement, since a number of programmes that include such sessions were unable to analyse their effects due to poor parental attendance (Barrett et al., 2005; Lock & Barrett, 2003; Misfud & Rapee, 2005). This is despite the fact that family factors seem to have a negative impact on child and adolescent mental health problems and accentuates the importance of their engagement and further assessments of these factors (Spence & Shortt, 2007). Despite some of the limitations noted, a variety of studies demonstrated the FRIENDS programme to have a positive impact upon children's emotional health. Furthermore, these findings emphasise the importance of universal programmes for childhood anxiety and that the delivery in school settings is particularly beneficial (e.g., Stallard et al., 2007).

Despite the supporting literature for prevention and early intervention programmes such as FRIENDS, most of the studies testing the effectiveness of the programme have been using self-report measures that may be questioned on the basis of children's accurate and genuine responses (Essau et al., 2012). However, including parent-and-teacher measures may decrease this limitation. Given the success of the FRIENDS programme (e.g., Shortt et al., 2001) an intervention programme, similarly orientated, yet developed to deal with SA in particular, is likely to present successful reductions in levels of SA and it will do so in less time,

and be easily accessible to teachers to learn and apply in their classroom. As previous studies have reported, children diagnosed with anxiety disorders present low levels of social skills (Strauss, Frame, & Forehand, 1987; Ollendick et al., 2010) and no particular coping skills (Parker, Rubin, Price, & DeRosier, 1995), which can both lead to the development and maintenance of SAD. In addition, it has been shown that not all individuals achieve optimum responses following standard CBT packages (e.g., Compton et al. 2014). Consequently, an early intervention programme based on successful aspects of CBT, as well as the emphasis on enhancing regulation skills, could help reduce high levels of SA in children more efficiently. This, in turn, could enhance children's social, emotional, and academic skills, and may contribute, as a constituent part, to the concepts and aims of the PSHE education.

#### *2.8.8 Other Relevant Components*

Taking the advantages and disadvantages of CBT into account it is feasible to include other successful approaches. Due to the lack of success in some treatment programmes, several authors suggest the inclusion of Emotion Regulation (ER) components, which support the identification and recognition of emotions and the regulation of unsettling emotions in order to enhance treatment efficacy (e.g., Hannesdottir & Ollendick, 2007). This has been supported by Suveg, Kendall, Comer, and Robin (2006), who added an ER treatment component to an otherwise standard CBT programme for children with anxiety disorders and showed overall positive results on the children's ability to identify emotional states and understand ER strategies. However, in 2009, Suveg, Sood, Comer, and Kendall suggested CBT

for anxious youths to not enhance ER skills beyond worry. While the results indicated improvements in the regulation of worry, anxiety and emotion awareness, there were no changes reported in the regulation of other emotions, such as sadness or anger. Hence, a more detailed approach for regulating emotional experiences and emphasising a wider range of ER skills may strengthen CBT programmes (e.g., Suveg et al., 2006).

In the light of these results, Kley and colleagues (2012) investigated the differences in maladaptive anxiety regulation strategies in children and found these to be a possible predictor of change in SAD post-treatment. Moreover, child and parent ratings revealed an improvement in SAD symptoms after a 9-week (12 sessions) CBT treatment. In particular, the Social Phobia and Anxiety Inventory for Children (SPAI-C; Beidel, Turner, & Morris, 1995) was demonstrated to be a significant predictor for the reduction of SAD symptoms, with more socially anxious children at pre-treatment reporting larger reductions in SAD at post-treatment. These findings are in line with previous research examining the efficacy of CBT in the treatment of anxiety (e.g., Silverman et al., 2008). However, the medium to large effects of this study shows that not all children benefit equally from CBT, which is confirmed by other studies as well (e.g., Heimberg, 2002; Hitchcock et al, 2009). It would therefore be useful to examine other factors that could improve treatment for all children. Furthermore, contrasting previous findings on the association between parent and child psychopathology, the authors failed to find that higher levels of parental psychopathology lead to fewer improvements in SAD in children. The authors reported the levels of parental psychopathology to have been rather low,

leaving the possibility of a floor effect. In addition, the inconsistency in findings may also be due to methodological differences in the assessments of parental psychopathology in general together with more specific symptoms of anxiety and depression (Thienemann, Moore, & Tompkins, 2006; Victor, Bernat, Bernstein, & Layne, 2007) and the severity of the symptoms. Thus, a more precise measurement of psychopathology could be useful, such as that by Cooper, Gallop, Willetts and Creswell (2008).

The study by Cooper and colleagues (2008) suggested maternal SAD to negatively influence treatment outcomes as opposed to maternal GAD. This may be due to the specificity of the disorder. Additionally, their findings showed that maladaptive anxiety coping and self-consciousness predicted changes in SAD. Similarly, research with adults and SAD demonstrated reductions in self-consciousness to be linked with greater treatment improvements (Hofmann, 2000; Woody et al., 1997). In conjunction with that, Hodson and colleagues (2008) suggested self-focused attention to be a predictor for SAD in children aged 11 and 14 years. Accordingly, treatments for young individuals with SAD ought to also address self-consciousness in order to achieve improvements (Higa & Daleiden, 2008). Moreover, Waters, Wharton, Zimmer-Gembeck, and Craske (2008) argued that the supplementation of traditional CBT with training that directs the centre of attention towards the task or features of the environment benefited adults with SAD more (Rapee et al., 2009a). Consequently, successful attention retraining techniques for adults could be a useful supplement or addition to traditional treatments in children diagnosed with anxiety disorders (Cowart & Ollendick, 2010).

Furthermore, Suveg and colleagues (2009) found reduced maladaptive anxiety regulation strategies to predict changes in SAD scores through child reports. However, Kley and colleagues (2012) implied that if the study was replicated, which suggested parents rating their children as less anxious the more maladaptive ER strategies the child uses, parents would present an inadequacy in identifying their child's inability to regulate anxiety, to the extent of possibly mistaking the child's behaviours for a sign of anxiety reduction. Hence, there is an increased necessity to inform parents in more depth about functional and dysfunctional regulation skills that children may engage in to cope with their anxiety.

Overall, these findings suggest programmes specifically targeting ER to be promising in the attempt to improve treatment outcomes (Hannesdottir & Ollendick, 2007; Suveg, Southam-Gerow, Goodman, & Kendall, 2007). Moreover, variations in self-consciousness have been shown to be dependent on alterations in maladaptive ER skills (Werner & Gross, 2010). According to Werner and Gross (2010), the foundation of functional ER skills is the control of attentional resources. This is in line with previous findings which suggest that heightened self-focused attention also characterises a maladaptive ER strategy (Muris, Mayer, Van Lint, & Hofman, 2008). Subsequently, it seems fundamental for children with SAD to adapt and relocate their attention to positive or at least neutral stimuli to obtain and increase the possibility of recognising positive reactions from interaction partners (Werner & Gross, 2010).

Taken together, the consensus that anxiety has negative consequences for a person's social, personal, and academic life emphasises the necessity of preventing



the development or maintenance of SAD. Considering the benefits highlighted, school-based programmes are helpful and their wider implementation should therefore be encouraged and supported. A prevention programme for children with and without signs of SA delivered in schools could reduce the risk of developing this disorder. Furthermore, it could enhance the necessary social- and emotion regulation skills required for this in a non-stigmatising way which is both universal and targeted (Barrett, Farrell, Ollendick, & Dadds, 2006; Essau et al., 2012; Mzarek, & Haggerty, 1994; Thornicroft, & Tansella, 1999). A mixture of a universal and targeted programme avoids the isolation and labelling of children while increasing essential skills for both populations.

## Chapter Three: Emotions

### *3.1 Definition*

Gross states that “emotions, a subtype of affect, are flexible response sequences elicited by internal or external events appraised as relevant to an organism’s well-being” (1998, cited in Amstadter, 2008, p. 211). What initially arouses emotions is the personal meaning of the aim or personal relevance of the situation (Gross & Levenson, 1993). In essence, emotions develop an internal feeling, and drive the individual to perform in a particular way (Frijda, 1988). Emotions are a key element of everyday life and known to be uncontrollable and overly intense at times, which in turn can become incapacitating in daily life (Frijda, 1986; Nezlek & Kuppens, 2008). According to the literature, negative emotions, such as anger and fear, occur more often and have a greater impact on an individual, implying a more challenging regulation of those reactions (Taylor, 1991).

Considering the fact that emotions can influence important processes, such as learning, decision-making, memory, health, and general wellbeing (Cacioppo & Gardner, 1999; Gross, 2002) the lack of their regulation may lead to psychological discomfort and dysfunction of these cognitive processes (Gross & Thompson, 2007, in Mikolajczak, Nelis, Hansenne, & Quoibach, 2008; Nolen-Hoeksema, 2000). This, therefore, leads to the need for regulating emotions, albeit, in order to be able to do this successfully, one needs to have a sufficient level of Emotion Knowledge.

### *3.2 Emotion Knowledge*

“Discrete emotion knowledge is defined as the ability to understand relatively unambiguous cues of discrete emotions expressed in traditional channels (facial expressions, vocalizations, gestures, social contexts; Izard, 2001)” (as cited in Trentacosta, 2010, pp.1-2). Identical to the dysregulation of emotions, poor emotion understanding is seen as a deficit often associated with serious psychiatric disorders (e.g., Baron-Cohen, 2002; Brüne, 2005) and other health disabilities (e.g., Boni, Brown, Davis, Hsu, & Hopkins, 2001). Moreover, understanding emotions is suggested to be a significant predictor of the development of social competence (Denham, 1998). Correspondingly, Halberstadt, Denham, and Dunsmore (2001) found that children who have an increased ability to understand emotional cues in social environments are suggested to develop greater social skills, and as a result form positive interpersonal relationships, something children with SAD lack (Alfano et al., 2006; Rapee & Spence, 2004). Thus, the basic comprehension of emotion may translate into social competence (Trentacosta, 2010).

This is in agreement with earlier research looking into the relationship of distinct emotion knowledge and signs of play skills, social adjustment, and social status in preschool children (Goldman, Corsini, & DeUrioste, 1980; Krantz, 1982). Conversely, earlier findings with elementary school children found less consistent associations between emotion knowledge and social competence (Gottman, Gonso, & Rasmussen, 1975; Vosk Forehand, Figueroa, 1983). Across time, however, more research on this subject demonstrated relatively consistent support for the link between emotion knowledge and social competence in diverse samples (e.g., low

income and/or minority populations, Izard, 2002; school-age children and young adolescents; Mostow, Izard, Fine, & Trentacosta, 2002), underlying the importance of emotion knowledge.

### *3.2.1 Emotion Knowledge and SAD*

With regard to SAD, social skills deficits in children diagnosed with SAD may make the assembly of emotional information from the social environment more difficult (McClure & Nowicki, 2001), which explains the presumption that children with SAD acquire discrepancies in their understanding of emotions due to incongruities in social interaction. As a result, those children are likely to experience more difficulties socially over time and as a consequence develop persistent arrays of negative emotions (Fine, Izard, Mostow, Trentacosta, & Ackerman, 2003). According to Trentacosta (2010), negative emotions result in many children internalising problems that lead to mood or anxiety disorders later in childhood or adolescence. However, as Eisenberg, Hofer, and Vaughan (2007) propose, emotion knowledge is the ability to attend to emotions. Yet attending to emotions is said to be distinct from understanding emotions (e.g. Palmieri, Boden, & Berenbaum, 2009), which suggests that these concepts are not always related. While, intrapersonal knowledge refers to the understanding of one's own emotions and inner feelings, interpersonal knowledge indicates the understanding of other peoples' emotions and feelings. However, these two concepts could be connected as the ability to understand other peoples' feelings may rely on the capability to imitate part of the emotion intrapersonally (Niedenthal, Barsalou, Ric, & Krauth-Gruber, 2005). Emotion knowledge is therefore an element of emotional intelligence (Salovey &

Mayer, 1990) and related to constructs such as theory of mind (Baron-Cohen, Leslie, & Frith, 1985).

The deficiency of emotion knowledge was found in numerous disorders, yet is suggested to be the strongest in SAD (Mennin, McLaughlin, & Flanagan, 2009; Summerfeldt, Kloosterman, Antonym, McCabe, & Parker, 2011; Trentacosta, 2010). This may be due to interpersonal issues presenting a core characteristic of SAD, where individuals diagnosed with SAD are known to misinterpret other peoples' emotions in a negative way (Beck & Emery, 1985) or overlook them completely as a result of their self-focused attention (Clark & Wells, 1995). Boden and Berenbaum (2012) found an association between poor emotion knowledge and subclinical paranoia and suspiciousness, which are characteristic of some individuals with SAD (Kashdan, McKnight, Richey, & Hofmann, 2009). Thus, SAD and poor intrapersonal emotion knowledge are related (e.g. Evren & Evren, 2007; Summerfeldt et al., 2011), whereas results for interpersonal emotion knowledge are inconsistent. While some studies (e.g., Melfsen & Florin, 2002; Winton, 1995) have found increased levels of interpersonal emotion knowledge, others demonstrated decreased levels of emotion knowledge in individuals with SAD (e.g. McClure & Nowicki, 2001; Montagne et al., 2009). Summerfeldt and colleagues (2011) established that intrapersonal emotion knowledge is more strongly associated with functional impairment than interpersonal emotion knowledge amongst individuals with SAD and non-clinical SA. Hence, intrapersonal emotion knowledge may be more precarious than interpersonal emotion knowledge with regard to psychosocial functioning in patients with SAD. This, however, disputes previous theories that

have related SAD to interpersonal difficulties (e.g. Clark & Wells, 1995; Dannahy & Stopa, 2007). This may be due to some research suggesting that individuals with SAD pay more attention to social cues by inspecting other peoples' expressions for signs of negative evaluation (Rapee & Heimberg, 1997), whilst other research proposes that individuals diagnosed with SAD are extremely self-focused in social situations (Clark & Wells, 1995). Both may be due to the view that information-processing biases for threat in childhood anxiety are automatic (Hadwin, Donnelly, French, Richards, Watts, & Daley, 2003).

The most recent findings by O'Toole and colleagues (2012) suggest a negative relationship between SAD and intra- as well as interpersonal emotion knowledge. These findings support recent theories, which propose that reduced emotion knowledge plays a fundamental role in anxiety disorders overall (Mennin, Holaway, Fresco, Moore, & Heimberg, 2007), and particularly in SAD (Turk, Heimberg, Luterek, Mennin, & Fresco, 2005; Mennin et al., 2009). These findings are reinforced by attentional studies that disclosed individuals with elevated symptoms of SAD to have biased attention towards negative evaluations, while not paying as much attention to such signs at different times (Bögels & Mansell, 2004; Staugaard, 2010). Nevertheless, research has found a link between poor emotion knowledge and the tendency to misinterpret other peoples' emotions (Boden & Berenbaum, 2012), which therefore requires future prevention and intervention programmes to include emotion awareness enhancement strategies. Moderator analysis indicated individuals diagnosed with SAD to be able to identify distinct emotions, such as happiness and anger, yet to present more difficulties in emotion

knowledge in situations of higher emotional complexity that rely on overall social understanding (O'Toole, Hougaard, & Mennin, 2012). This, in turn, can lead to poorer presentation of emotions (Barrett, 2004) and should be investigated further in SAD.

Consequently, children that present early social deficits because of exposure fragility to social situations, social withdrawal, or SAD in general may have difficulties in identifying and understanding emotional cues appropriately. Over time, this in turn may lead to increased social deficits, negative emotions, and eventually the internalisation of psychopathology (cf. McClure & Nowicki's, 2001). Therefore, supporting and enhancing emotion knowledge, by developing an understanding of emotions is an important aspect to incorporate into early intervention and prevention programmes. Through such training, the ability to manage and utilise emotions adaptively can be increased which in turn supports pro-social outcomes and thus reduces the risk for developing SAD.

### *3.3 Emotion Regulation*

A growing body of research has underlined the importance of emotional competence in a child's adaptive social functioning and psychological adjustment (e.g., Saarni, 1999; Suveg et al., 2006; Werner & Gross, 2010) in order to perform adequately in socially and emotionally challenging circumstances. The lack of emotion regulation (ER) may thereby lead to psychological discomfort and dysfunction of these cognitive processes (Gross & Thompson, 2007, cited in Mikolajczak et al., 2008).

According to Kokkonen and Pulkkinen (1999, p.914) ER is “the process of initiating, maintaining and modulating the occurrence, intensity or duration of internal feeling states and physiological processes related to emotions”. On that account, ER is an active and concrete strategy applied in order to guide behavioural responses (Koole, 2009). Further research has classified these processes in more depth creating different models of the ER concept. According to Gross and Thompson (2009), the regulation processes of emotions may take place in or out of conscious awareness and thus be automatic or voluntary. They may also occur at different times during the emotion eliciting experience (Koole, 2009). Even though ER is frequently applied, the way in which children regulate emotions is highly variable due to the many changes growing up holds and their level of emotion knowledge. In addition to that personality, interpersonal interactions, early life experiences, environmental factors, as well as the cultural background of a person, contribute to the way in which emotions are regulated (Koole, 2009; Morris et al., 2007).

While effective ER consists of the identification of emotions and flexible employment of suitable coping strategies for the situational context, Emotion Dysregulation refers to the inability of modifying incongruous and ineffective emotions in order to manage distress in given situations (Cisler, Olatunji, Feldner, & Forsyth, 2010; Gross & Thompson, 2009). There are different views on the benefits and importance of positive emotions along with the importance of inhibiting positive affect. Whereas ER strategies such as rumination or suppression (which display the reverse to hedonistic ER, that intensifies positive emotions) have been found to lead to psychological disorders as well as to negative impacts on an individual's social



life (Nolen-Hoeksema, 2000), positive affects have been shown to enhance pro-social behaviour such as helpfulness and kindness, and hence to benefit other individuals as well (Isen, 2000). Subsequently, the dysfunction of regulation with regard to negative emotions may lead to impairments in subjective, physical, and mental health, as well as an individual's social relationships (Mikolajczak et al., 2008). Furthermore, other findings such as those by Huppert, Baylis, Kerverne (2004), underline the importance of positive emotions for a longer healthy life expectancy and for the reduction of the risk towards physical diseases.

Despite a small amount of research that has looked into the benefits of restraining pleasant and maintaining unpleasant mood, in situations where this is more appropriate or where positive emotions could be distracting and inhibit more realistic thought (Parrott, 1993; Schwarz & Bless, 1991, cited in Parrott, 1993), the regulation of negative and positive emotions is found to be essential. Consequently, regardless of the advantages and disadvantages of positive or negative moods, the repair of dispositions appears valuable. It is therefore not surprising that ER has achieved more and more interest over the last years, providing insight into mental functioning and the high impact cognitive processes have on wellbeing (Bebko, Franconeri, Ochsner, Chiao, 2011; Gross, 2013; Gross & Munoz, 1995; Hofmann, Sawyer, Fang, & Asnaani, 2012b). Skills that focus on the regulation of emotions are a key element of optimum health (Kotsou et al., 2011). The effective regulation of emotions has been associated with increased life satisfaction (Gross & John, 2003) and enhanced interpersonal relationships (Koole, 2009). Thus, ER is a critical component of development, due to its early role in developing social and emotional

skills, which support the maintenance of relationships, particularly positive peer relations (Denham et al., 2003; Keenan, 2000; Hubbard & Coie, 1994). It is further vital in the development of cognitive abilities, which have been positively associated with early academic success (Graziano, Reavis, Keane, & Calkins, 2007; Trentacosta & Izard, 2007; Denham, 2006). On the other hand, emotion dysregulation has been shown to have severe negative consequences. It has been related to elevated levels of stress with the resulting negative effects on the psychological and physical wellbeing of an individual (McLaughlin & Hatzenbuehler, 2009). This may manifest as anxiety (Cisler & Olatunji, 2012), SAD (Goldin, Manber, Hakimi, Canli, & Gross 2009a), as well as depressive symptomology (Joormann & Gotlib 2010).

Children at-risk for or diagnosed with a psychological disorder seem to present some difficulty with expressing their emotions (e.g., Thompson & Calkins, 1996). The three most commonly found are non-normative expression, the inhibition of expression, and poor control of expression. All three forms of expression have been linked to understandable efforts of ER, yet may not be the most appropriate to regulate emotions; however the application of appropriate ER strategies (i.e., coping) is known to increase with age (Kopp, 1989). According to Southam-Gerow and Kendall (2002), the type of relationship between parent and child (usually between mother and child) pre- and post-attachment solidification relates to the development of ER. This is in line with previous research emphasising the link between poor attachment, a parent who meets psychiatric diagnosis, maternal rejection, and marital status of the parent, with poorer outcomes of ER (e.g., Cassidy, 1994; Field, 1994; Hofer, 1994; Morris et al., 2007). Furthermore, cultural and ethnic variables may

contribute differently to the development of ER, considering the different views cultures share on the expression of emotion and their regulation (e.g., Fredrickson, 1998; Friedlmeier & Trommsdorff, 1999). As stated by Weisz and colleagues (e.g., McCarty et al., 1999; Weisz et al., 1988), the difference in the expression of problem behaviours, for example, and the way in which they are dealt with, depends on the culture. Moreover, at-risk and disordered youth present different ER strategies in contrast to other youth, because diverse contexts nurture different ER strategies (Thompson & Calkins; 1996, p. 163). The authors, Southam-Gerow and Kendall (2002), therefore suggest that a model of “optimal” ER must be considered contextually bound.

Considering that ER can develop in early childhood and has profound effects upon the child’s behavioural and social competency into adolescence and adulthood (Halberstadt et al., 2001), it is essential to support the right use of ER. Some children are more reactive to environmental stimuli and negative emotions, which in turn make ER more challenging. Eisenberg and colleagues (1996a) investigated the relations of ER and temperament to problem behaviour in school aged children. Their findings displayed an association between low levels of ER and high temperament and behavioural problems. In addition, ER shielded the effects of negative temperament, emphasising the significance of ER. Thus, the necessity to regulate emotions in order to enhance psychological and physiological well-being, improve social behaviour, social relations, as well as social competence is well known (Denham, von Salisch, Olthof, Kochanoff, & Caverly, 2002b).

In summary, findings suggest that adolescents diagnosed with a psychological disorder express emotions more negatively and are less able to regulate the emotions as opposed to unaffected youths (e.g., Eisenberg et al., 1996a; Shields & Cicchetti, 1998). This, in turn, concludes that certain forms of ER are associated with psychological disorders. Hence, the development of more sophisticated understandings of emotion and the increased ability to regulate emotions appropriately promotes a number of adaptive processes, such as coping and social functioning (e.g., Brown & Dunn, 1996; Garner & Power, 1996; Hubbard & Coie, 1994) and further has been associated with cognitive progress such as the development of Theory of Mind (Cutting & Dunn, 1999; Hughes & Dunn, 1998). Conversely, delayed or inadequate understanding of emotion may increase the risk of developing psychological disorders in youth. A more recent study by Eisenberg and colleagues (2009) showed that low ER and the intensity of negative and positive emotionality predicted problem behaviours in elementary school children. This is in line with findings suggesting that anxious children exhibit greater difficulty in employing effective ER strategies than their non-anxious counter-parts (Carthy, Horesh, Apter, & Gross, 2010). Based on these findings, childhood anxiety could be conceptualised as a dysregulation of anxiety responses and general negative emotions (Weems, 2008).

### *3.3.1 The Process Model of ER*

According to Parrot (1993) people may decrease, increase or maintain, both negative and positive emotions, while Gross (1998b) refers to the emotion-generating process during which emotions can be regulated at different points. In accordance with the process model of ER (Gross, 1998b) emotions can be regulated at five points: situation selection, situation alteration, attentional organisation, and cognitive change. The various response options at each of these points are arbitrary. Gross and John (2003) differentiate between ‘antecedent emotion-regulatory strategies’ (e.g., cognitive change, e.g., reappraisal) and the ‘response-focused strategy’ (response modulation, e.g., suppression). While antecedent-focussed ER refers to the process that occurs before an emotion arises, response-focussed ER refers to the ensuing procedure after the emotion has been experienced.

Reappraisal is one form of cognitive change that has received particular attention over the years and refers to the ER strategy that alters a situation to modify its emotional impact. Suppression, on the other hand, constrains the expression of the emotion once it has occurred and is a form of response modulation. ER has been shown to have a significant impact on social and emotional functioning (Gross & John, 2003); thus, deficiencies in the ability to regulate emotions can increase the disposition to psychological disorders, including anxiety (Mennin, Heimberg, Turk, & Fresco, 2005). The study by Farmer and Kashdan, (2012) explored the effect of daily ER strategies on the social lives of people with elevated SAD. Their results indicated that SAD has an impact on the frequency, type, and consequences of reported ER approaches. Individuals with elevated SAD reported more frequent use

of positive suppression, fewer intense positive emotions, and slightly less positive social events on the following day. Furthermore, cognitive reappraisal resulted in fewer negative social events on the subsequent day for people low in SAD, but not for individuals high in SAD.

### *3.3.2 The Benefits of Reappraisal over Suppression*

Based on Gross' process model of ER, there are various regulatory styles. The benefits of ER depend on the nature of emotion regulatory strategies applied. Due to a limited amount of literature on reappraisal and suppression in children, however, the following will concentrate on existing studies of both children and adults. According to Garland, Gaylord, and Park (2009), the deliberate control over ER processes can significantly determine the overall status of human health and well-being. Within this notion, different ER strategies have been found to relate to different health outcomes, as Haga, Kraft, and Corby (2009) suggested in their study on cognitive reappraisal and expressive suppression. Their findings suggested a positive association between cognitive reappraisal and well-being, as well as social functioning, whereas expressive suppression was negatively associated with these constructs. These findings are in line with other research suggesting reappraisal as an adaptive ER to be associated with enhanced life satisfaction and decreased levels of negative emotional experiences, whereas expressive suppression as a maladaptive ER, was associated with decreased well-being and an increased vulnerability to negative symptoms (e.g., Quoidbach, Berry, Hansenne, & Mikolajczak, 2010; Martini, & Busseri, 2010).

In earlier findings by Gross (1998a) participants in the experimental group (EG) were trained to apply reappraisal during a video clip so as to down-regulate negative emotions, while the control group (CG) was instructed to simply watch the video. As predicted, the EG demonstrated decreased levels of negative emotions as opposed to the CG. This is in agreement with findings of Murphy, Shepard, Eisenberg, and Fabes (2004) who examined the social functioning of young adolescents in relation to negative emotionality and regulation during early adolescence. This also included assessments of previous time points (two, four, and six years earlier). The authors revealed that children high in social functioning, as rated by their teachers and parents, were mostly perceived as having elevated ER and low negative emotionality during early adolescence as well as at previous time periods. On the contrary, children who reported low social functioning across time demonstrated lower ER and higher negative emotionality. This suggests a significant link between negative emotionality, limited ER, and social functioning. Although their findings are limited to self-report measures, the long follow-up period strengthens the validity of these results. Accordingly, more recent literature has demonstrated that cognitive strategies act as predictors of both social functioning problems and associated distress (Mihalca & Tarnavska, 2013).

According to Thompson (1991), cognitive ER refers to the ability to regulate and manage emotional reactions in negative scenarios. This includes positive reappraisal and putting events or responses into perspective (Garnefski, Kraaij, & Spinhoven, 2001). Thus, the presented findings support the notion that the development and enhancement of more beneficial ER strategies is essential. In line

with this view is the study by Flouri and Mavroveli (2012) that looked into a sample of adolescents and found reappraisal to be a more adaptive ER strategy than suppression. Their results revealed further that avoidance and suppression were associated with increased problem behaviour, whereas cognitive reappraisal was not, thus, suggesting that the latter to acts as a protective regulation factor. This is in accordance with previous studies that found a link between adolescent emotional problems and response styles (Hilt, McLaughlin, & Nolen-Hoeksema, 2010). The findings of Hilt and colleagues (2010) suggest a correlation between increased emotional and behavioural problems and maladaptive ER strategies (e.g., suppression, avoidance). Consequently, if avoidance and suppression retain this negative effect, irrespective of change in life stress, they both represent risk factors for broad emotional and behavioural maladjustment. However, the findings of Flouri and Mavroveli (2012) are limited, as some of their measures were not applied at baseline and although earlier research suggested some of the ER strategies to be constant over time in older children and adolescents, there is also evidence for change (Gullone, Hughes, King, & Tonge, 2010; Moos & Holahan, 2003).

Nonetheless, the study by Carthy and colleagues (2010) also supports the perception of reappraisal being advantageous. Their sample consisted of 49 children with a primary diagnosis of GAD, SAD, separation anxiety, and 42 age- and gender-matched non-anxious controls. Participants were asked to simply view some threatening pictures or asked to use reappraisal to reduce their negative emotional response. Results of the self-report measures and content analysis of reappraisal responses suggested children with a primary diagnosis to experience increased



negative emotional responses to the images, a less successful application of reappraisal ability, yet intact ability to reduce their negative emotions following reappraisal. In addition, these children reported less regular practise of reappraisal in everyday life. It is noteworthy, that reappraisal effectively reduced negative emotions for both anxious and non-anxious children with no difference in its efficacy between the groups. As a result, research over the past decades has been able to show the beneficial consequences of applying reappraisal to interpersonal relationships and enhanced (psychological) well-being as opposed to regular suppression (Moore, Zoellner, & Mollenholt, 2008; Gross & John 2003). However, along with the benefits of reappraisal, research has also noted negative associations such as increased risk-taking behaviour (Magar, Phillips & Hosie, 2008). Nevertheless, the use of cognitive reappraisal and/or restructuring has been shown to enhance well-being and life satisfaction, and these effects are reversed when it is completed through expressive suppression.

Suppression, moreover, not only correlates with increased negative emotions (Gross & John 2003) and decreased social functioning (Muraven, & Baumeister, 2000; Murphy et al., 2004) but also heightened levels of obsessive thinking and depression (Corcoran & Woody, 2009; Marcks & Woods, 2005). This is in addition to reduced life satisfaction (Kashdan & Steger, 2006), and decreased interpersonal skills (Butler et al., 2003), which may be due to distracted and avoidant behaviour that suppression has also been known to lead to (Gross & John, 2003), as well as decreased memory recall (Richards, Butler, & Gross, 2003; Richards & Gross, 2000) among others. The negative consequences of suppression are assumed to be a result

of internal conflict that stems from false representations of one's feelings (Sheldon, Ryan, Rawsthorne, & Ilardi, 1997), and may further lead to low self-esteem and social isolation. The decrease in memory or social functioning related to suppression may be due to the late occurrence of this ER strategy and the effort it involves that drains an individual's cognitive resources (Gross & John, 2003).

Despite the negative consequences of suppression, research has found this to be an adaptive strategy in some situations (Schutte, Manes, & Malouff, 2009) such as in working, school, or social settings that involve suppressing negative emotions for the purpose of positive working and interpersonal relationships. Moreover, different cultures may perceive diverse ER strategies as more advantageous than others. In example, Asian cultures perceive suppression as an adaptive ER strategy unlike more Western cultures (Butler, Lee & Gross, 2007). In conclusion, suppression is not a maladaptive ER strategy per se; however the context and frequency in which it is applied can become problematic. Thus, applying suppression as a primary ER strategy most of the time, despite the availability of other more beneficial strategies, such as reappraisal, can have more negative consequences on an individual's life (particularly due to its maintenance of adverse affect and the down-regulation of positive affect). Reappraisal, on the other hand, presents the individual with a more adaptive ER style, which has generally more positive effects on the individual's life (Gross, 2002; 2013).

### *3.3.3 Emotion Regulation and Dysregulation in SAD*

Based on the aforementioned it is inevitable that individuals diagnosed with SAD experience difficulties in regulating their emotions adaptively (e.g., Turk et al., 2005; Werner & Gross, 2010). With regard to anxiety disorders in general, Mennin's (2005) introduced the Emotion Dysregulation model that suggests that individuals diagnosed with anxiety disorders display amplified intensity of emotions, difficulties in differentiating between them, a limited understanding of emotions, and finally the inability to manage emotions. This has been supported by further research that concentrated mainly on patients with GAD (McLaughlin, Mennin, & Farach, 2007; Roemer et al., 2009) and other studies that found SAD to also be associated with related problems in ER practices (Mennin et al., 2009). Furthermore, this is in line with, Turk and colleagues (2005) who explored these associations with undergraduate students and found that participants with higher levels of SAD revealed more difficulties in recognising, describing and regulating emotions than their non-anxious counterparts. Moreover, the deficits in ER were found to be specific to SAD. Participants diagnosed with SAD attended less to their emotions, and found it more difficult to describe them by being less expressive of both positive and/or, negative emotions in contrast to individuals diagnosed with GAD and healthy controls. Hence individuals affected by SAD appear to be less likely to describe and reveal their emotions to others (e.g., employ socially-orientated ER strategies) than healthy individuals, yet an analogue measure for SAD was used in this study limiting the general application of these results to clinical samples. However, there is a link between distinctive patterns of emotion dysregulation and the fact that these appear to be explicitly in potential social threat situations (Sung et

al., 2012). This has been supported by recent findings of Goldin and colleagues (2009a). The authors showed that individuals diagnosed with SAD were unable to apply ER in socially threatening situations and generally experience higher negative emotional reactivity. Therefore, it seems crucial to teach individuals diagnosed with SAD or those prone to this disorder ER strategies and skills that enhance its implementation and effectiveness in relieving their symptoms.

Recent studies suggest increased functional impairments to be a result of overstated negative emotional reactions, limited positive reactions, and challenges in ER (Goldin et al., 2009a). Generally, deficits in ER appear to have direct as well as ambiguous impacts on social functioning (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Contreras & Kerns, 2000; Eisenberg, Fabes, & Losoya, 1997; Murphy et al., 2004; Saarni, 1999). For example, the reduced ability to apply ER prior, during, or after a social interaction could add to the incessant anxiety and avoidance of interactions. Moreover, individuals diagnosed with SAD have been found to often apply maladaptive ER strategies such as suppression of positive (Turk et al., 2005; Werner & Gross, 2010) and negative emotions (Erwin, Heimberg, Schneier, & Liebowitz, 2003; Spokas, Luterek, & Heimberg, 2009), wherein the suppression of positive emotions is found to occur more often when compared to non-anxious individuals and individuals diagnosed with GAD (Turk et al., 2005).

In view of the fact that some strategies of ER appear to play a crucial part in the majority of psychopathological disorders it is rather surprising that research in clinical populations is scarce (e.g., Casey, 1996; Southam-Gerow, & Kendall, 2002). The few findings that emerged identified a significant association between ER and

anxiety disorders (e.g., Casey, 1996; Southam-Gerow & Kendall, 2000; Zeman, Shipman, & Suveg, 2002) and that emotion dysregulation are core features of SAD (e.g., Hermann, Ofer, & Flor, 2004; Hofmann, 2004). Teachman and Allen (2007) found that levels of emotional intensity are related to implicit rejection. Notwithstanding the fact that heightened levels of arousal improve performance, such high levels may result in restrained or excessive control of emotional experience, which have both been inversely related to social and emotional competence (e.g., Eisenberg, Cumberland, & Spinrad, 1998). Consistently, over-arousal of positive and negative emotions has been linked to less adaptive reactions, and negative affect has been shown to generate further greater levels of arousal in opposition to positive emotions (Bradley, 2000). As a result, the occurrence of harmful experience as a central component of childhood anxiety (e.g., Laurent et al., 1999) along with the physiological hyper-arousal, acting as a characteristic of anxiety disorders (Clark & Watson, 1991), set children diagnosed with anxiety at serious risk of emotion dysregulation. This, in turn, leads to the inability to cope with anxiety provoking situations in the most efficient way. Considering the increased levels of negative emotion including the reduced levels of positive affects in SAD this may have serious consequences for the improvement and prevention of SAD (e.g., Naragon-Gainey, Watson & Markon, 2009).

In 2004, Suveg and Zeman looked into the management skills of emotion, the role of emotional intensity and self-efficacy in ER in 8 - 12 year old children with anxiety disorders. Their results suggested that children who met the criteria of the DSM-IV (APA, 1994) for an anxiety disorder showed difficulty in controlling

negative experiences, indicating that ER should be the centre of research with anxious populations. Thereupon, the enhancement of positive affect, and the regulation of negative emotion, has found to be crucial in order to improve and prevent SAD (Moscovitch, Suvak, Hofmann, 2010). Furthermore, research has established that individuals diagnosed with SAD present reduced levels of identifying and comprehending their emotions (Decker, Turk, Hess, & Murray, 2008; further evaluated in 2.2). This may explain their difficulty in controlling their emotions appropriately. The study by Clerkin and Teachman (2010) proposes that implicit associations not only relate to SAD but also relate causally to the reduction of anxiety. This was significantly supported by their experimental anxiety reduction intervention among highly socially anxious participants. Consequently, the enhancement of positive emotions, through ER, when exposed to a threatening situation in socially anxious individuals, is crucial in order to control their levels of SAD and its consequences.

### *3.4 ER-Based Treatments*

Considering the severity of emotion dysregulation, a number of training programmes focussing on emotional competence and coping skills have been developed. The main weakness, however, of current theoretical programmes is that they are not based on scientific theory and thus utilise techniques with an elusive psychological base (Kotsou et al., 2011). Moreover, most studies that evaluated ER-based treatments have not been applied on non-clinical samples and generally employ small sample sizes undermining the generalizability of findings (Baer, 2003).

In order to facilitate the development of an effective, practice-based, preventative, early intervention programme, it is crucial to assess and outline the advantages and disadvantages of relevant treatments including ER enhancement strategies. Although self-talk and PMR are less widely researched, they are both applied widely in CBT as well as ER training based on their positive impact on health and performance. These techniques may be advantageous, along with the novel use of training children to develop emotion knowledge and employ cognitive reappraisal. This is based on the positive health outcomes associated with these factors in the extant literature (Gross, 2013; Troy, Wilhelm, Shallcross, & Mauss, 2010; Werner, Goldin, Ball, Heimberg, & Gross, 2011).

#### *3.4.1 ER and Self-talk*

Self-talk consists of an internal dialogue that takes place within the individual throughout the day and thus refers to a form of intrapersonal communication (Hardy, Oliver, & Tod, 2009). Hardy (2006) critically reviewed self-talk and concluded it to be a vigorous, multidimensional construct containing verbal as well as non-verbal statements. The substance of these statements acts as a practical or motivational purpose to the speaker. However, the fact that the content of the speech contains interpretative aspects by the speaker is a crucial feature of self-talk, which is mostly overlooked in the literature (Hardy, Hall, Gibbs, & Greenslade, 2005). To be precise, the mode in which an individual employs self-talk, and the content of it, is highly subjective. It will, therefore, vary depending on various factors, such as personality, background, and behaviour of the person. Current literature in this respect lacks

ecological validity considering the variability of application. Furthermore, it is crucial to differentiate between positive and negative self-talk.

Children who suffer from SAD, in particular, usually hold negative self-talk, which enhances negative thinking and resulting misbehaviour (e.g., Kley et al., 2011). The use of positive self-talk could reduce unhelpful thoughts and the maladjustment in different scenarios (Beidas, Mychailyszyn, Podell, & Kendall, 2013; Calvete, & Cardenoso, 2002). According to Calvete and Cardenoso (2002, p.482), “positive and negative self-statements are cognitive products that reflect different, but interrelated, processes”. Hence, positive evaluation processes concerning oneself or the situation may stop distinct negative evaluation processes and vice versa. In essence, self-talk is found to have various benefits, from understanding own life experiences through motivational or instructional cues (Hackfort & Schwenkmezger, 1993). In addition, it could improve confidence by influencing attentional focus and regulating efforts (Theodorakis, Hatzigeorgiadis & Chroni, 2008). Past literature reported associations between self-talk and self-regulation (Fernyhough & Fradley, 2005), self-efficacy (Hardy et al., 2005), problem solving (Depape, Hakim-Larson, Voelker, Page & Jackson, 2006) and performance (Hatzigeorgiadis, Theodorakis, & Zourbanos, 2004). It has also been found to play an essential part in the development of personal (Gardner, 1999) and emotional intelligence (Salovey & Mayer, 1990) due to its enabling function of incorporating other peoples’ views into their inner dialogue (Lane, Thelwell, Lowther, & Devonport, 2009). As a consequence, a key component of CBT is the substitution of negative self-talk with positive or neutral self-talk (Wilding & Milne, 2010; Kendall



& Choudhury, 2003). It further enables the acceleration, preservation, and amplification of positive emotions (Larsen, 2000) and mood repair (Salovey, Mayer, Goldman, Turvey & Palfai, 1995), thus enhancing adaptive ER strategies.

Emotional disorders are usually treated by diverting the attention of suffering individuals to the actual task, from past failures or negative thoughts, through the application of more adaptive and self-affirming cognitions (Davis, Robbins-Eshelman, McKay, 2000). The application of self-talk, thereby aids individuals to concentrate on positive aspects of a situation, which, in turn, can be confidence building and increase self-awareness (Zinsser, Bunker, & Williams, 2006; Kirschenbaum, 1997). The emphasis lies on positive self-talk; since phrases such as 'have to' or 'must' can be quite pressuring, a positive linguistic structure is essential. For instance, 'don't give up' is replaced with 'keep going' in order for the focus to be on the desired action. Negative self-talk has been associated with depression (e.g., Kelly, Zuroff & Shapira, 2009), guilt (e.g., Kubany et al., 2004), and anxiety (Goldin, Manber-Ball, Werner, Heimberg & Gross, 2009b). Accordingly, Kendall and Treadwell (2007) suggested the reduction of negative self-talk to have a positive impact on treatment outcomes in adolescents with anxiety disorders.

A current weakness in existing research is the deficiency of utilising self-talk as an adaptive ER strategy. Based on the theoretical background, negative emotions can lead to increased negative self-talk (Bower, 1981), which in turn can maintain or intensify negative affect. Positive self-talk on the other hand, can preserve or reinforce positive affect (hedonistic ER, Larsen, 2000) and in turn act as an ER strategy functioning in mood repair (Salovey et al., 1995). As a result research

should utilise positive self-talk as an adaptive strategy for ER in the prevention and intervention of psychological disorders.

#### *3.4.2 ER and Progressive Muscle Relaxation*

As introduced in 2.8.4 Progressive Muscle Relaxation (PMR; Bernstein, Borkovec, & Hazlett, 2000) refers to a relaxation technique that aims for maximal rest by tensing and relaxing muscles in a systematic way (Robb, 2000; Simpson, Suárez & Connolly, 2012). It is usually applied for the management of bodily arousals that often accompany anxiety (Rodebaugh et al., 2004). The technique educes psychological as well as physiological relaxation by decreasing the propensity of muscle tension, when the participant is anxious (McCaffery & Pasero, 1999). Although the mechanism that underlies PMR is still being investigated (Dolbier & Rush, 2012), it has been known that pressure receptors in the body are stimulated through the balanced tensing and relaxing of the major muscle groups, which in turn results in relaxed muscles and tension relief (Conrad & Roth, 2006). Consequently, this leads to vagal activity, slowing heart rate, and thereby decreasing blood pressure as well as stress levels (Lucini, Norbiato, Clerici, & Pagani, 1997; Pawlow & Jones, 2002; Rausch et al., 2006; Sheu et al., 2003). According to Keeley and Storch (2009), PMR for children specifically is intended to enhance the child's understanding of the dissimilarity between the tense and relaxed muscles, as well as providing an extended awareness of their body, so that when their muscles tense, during anxiety-producing situations, they recognise that they can reduce the tension.

Sessions on PMR usually teach children to take slow and deep breaths, to prevent the escalation of physiological symptoms. Additionally, such training

enhances awareness as it includes the encouragement of concentrating on a person or single object in the room so as to disengage from potentially anxiety-provoking stimuli. Finally, directing children to visualise a peaceful place may also enable a reduction in acute anxiety. As a result, these techniques provide children with alternative options, which they can employ prior to, or during, anxiety provoking situations. However, with regard to the treatment of SAD, PMR alone is generally known as insufficient (e.g., Hudson, 2005; Rapee, 2000; Rodebaugh et al., 2004), yet it forms the fundamental basis for applied relaxation, which has shown some efficacy in treating SAD. This has been supported in various studies that have utilised PMR effectively for the treatment of anxiety disorders as part of CBT (e.g., Anticich, Barrett, Silverman, Lacherez, & Gillies, 2013; Borkovec, Newman, Pincus, & Lytle 2002; Fresco, Mennin, Heimberg, & Ritter, 2013), and SAD (e.g., Christon et al., 2012).

According to the process model of ER, PMR is a response-focused ER approach due to the physiological, behavioural, and experiential transformations experienced upon triggering an emotion (Gross, 1998b). As outlined above, programmes including PMR training support the notion of PMR being an effective strategy in diverse samples (clinical, non-clinical, SAD, GAD, depressive) resulting in optimal wellbeing (Hall & Long, 2009) and enhanced life quality (Cheung, Molassiotis & Chang, 2003). The study by Kiselica, Baker, Thomas, and Reedy (1994) explored the impact of stress immunisation training including PMR, among others, in an adolescent sample. The treatment group, as opposed to the control group, demonstrated reduced levels of stress-related symptoms and trait anxiety;

these results were maintained at a four-week follow-up. In accordance, Rodebaugh and colleagues (2004) demonstrated in their review of SAD treatments that PMR forms the underlying basis for applied relaxation, which has been beneficial in the treatment of SAD. Christon and colleagues (2012), who included PMR in their treatment for SAD in adolescent females with selective mutism, support its beneficial effects. However, the limited sample size reduces the general application of the findings, even though, based on the beneficial results PMR has on the body, it provides ecological validity. Consequently, PMR remains a useful addition to CBT and ER training and was therefore incorporated in the ESST-C programme.

### *3.5 Emotion Knowledge, ER, and SAD*

A huge amount of research has shown maladaptive ER to be an underlying factor in SAD (e.g., Erwin et al., 2003; Hermann et al., 2004; Hofmann, 2004; Mennin et al., 2009; Spokas et al., 2009), particularly in the form of suppression or avoidance (Kashdan & Breen, 2008; Werner et al., 2011), and post-event rumination, which involves passive self-focus on feelings of distress as well as on their causes and consequences (Nolen-Hoeksema & Morrow, 1991; Clark & Wells, 1995). According to O'Toole and colleagues (2012), unlike ER, emotion knowledge concerns what an individual knows about emotions rather than how to regulate them, although emotion knowledge may play a fundamental role in adaptive ER. Individuals who have high emotion knowledge usually find it easier or more natural to choose the most suitable ER strategy for a given situation. This has been in agreement with studies that found increased emotion knowledge to improve the

ability of an individual to exercise adaptive ER (Izard et al., 2011). Indeed, past studies suggested that increased emotion knowledge is associated with the ability to regulate emotions (e.g. Barrett, Gross, Christensen, & Benvenuto, 2001b; Izard et al., 2008). Consequently, an emotional situation can be met with appropriate regulating strategies in individuals with sufficient emotion knowledge. However, problematic ER strategies can also lead to reduced emotion knowledge and ER, as Schultz, Izard, Ackerman, and Youngstrom (2001) suggested. They found ER to be a predictor of emotion knowledge over time, which emphasises the importance of appropriate ER. Thus, there is an interactional relationship between emotion knowledge and ER.

Generally individuals with SAD reported frequent suppression of positive (Turk et al., 2005; Werner & Gross, 2010) as well as negative emotions (Erwin et al., 2003; Spokas et al., 2009). However, suppression may increase physiological arousal (Gross, 1998b), whilst weakening receptiveness to positive events (Gross & Levenson, 1997). This is in agreement with the findings by Kashdan and Steger (2006), suggesting high trait SAD individuals to report the least number of positive events on the days they utilised suppression to control their anxiety. Hence, the immoderate use of suppression in people with SAD has shown to have an adverse effect on their positive experiences. The meta-analysis by Kashdan and Collins (2010) supported this notion as they reported a stable, moderate relationship between SAD and less recurrent and profound positive emotions. This also means that maladaptive ER could contribute to the negative influence of trait and daily SAD on positive occurrences in daily existence. Parrott (1993) explains that the down-regulation of negative emotions is useful in various social settings, while the down-

regulation of positive emotions, on the other hand, has been shown to be maladaptive. However, individuals high in SAD reported suppressing positive emotions more in contrast to non-anxious participants and participants with GAD (Turk et al., 2005). This may be due to possible feelings of discomfort in people with SAD when experiencing and voicing positive emotions especially in social evaluative situations. As a result, suppressing positive emotions could help to minimise the perceived attention toward them, but, simultaneously, impede efforts to build intimate relationships (Fredrickson, 1998; Otta, Lira, Delevati, Cesar, & Pires, 1994). This corresponds with previous findings that report individuals high in SAD to fear positive assessment (Kashdan, Weeks, & Savostyanova, 2011; Weeks, Heimberg, & Rodebaugh, 2008). Most of these studies, however, are based on adult samples and it would be interesting to explore and evaluate this in children.

Nevertheless, in most cases the lack of applying adaptive ER strategies, as seen in SAD (Goldin et al., 2009b; Werner et al., 2011) can lead to direct and indirect effects on social functioning (Lindahl & Markman, 1990). Furthermore, the inability to regulate emotions prior to, during or post social interaction may promote anxiety and avoidant behaviour, which in turn weaken relationships. This is in agreement with the more recent findings by Matthews, Kerns, and Ciesla (2014) that suggested the lack of emotional clarity, non-acceptance of emotions, and negative self-evaluation of the ability to manage emotions, to be related to GAD as well as SAD. Therefore, incorporating emotional awareness and ER strategies in intervention and prevention programmes could increase their benefits. Conversely, the overuse of suppression in individuals with elevated symptoms of SAD may

partly be due to the fact that individuals with SAD present reduced emotion knowledge (e.g. Werner et al., 2011); anything beyond the individual's understanding is likely to be fear-provoking and may be perceived as best dealt with by suppression or avoidance in the short term. Along these lines, Campbell-Sills and Barlow (2007) suggest that "individuals with anxiety and mood disorders may make counterproductive attempts to regulate acute affective episodes that lead to the exacerbation and persistence of unwanted emotions" (p. 543, cited in Tracy, Klonsky, & Proudfit, 2014). Thus, both poor emotion knowledge and ER difficulties play an important part in the development and maintenance of SAD. This highlights the necessity of including aspects of enhancing emotional understanding, ER, and clarity in treatment approaches. Available research that has incorporated techniques aimed at emotion knowledge and ER has been shown to be successful (Barlow, Allen, & Choate, 2004; Mennin & Fresco, 2009). However, the majority of these studies looked into clinical samples and their treatments were in form of interventions. It is therefore necessary to expand these findings to non-clinical samples, with a preventative approach, to possibly reduce the number of children developing SAD in the first place.

On the one hand, internal processes, such as biological predispositions, emotional cognitions, attention shifting, and the adaptive or maladaptive responses to physiological reactivity (Morris et al., 2007), as well as executive functioning (Thompson, Lewis, & Calkins, 2008) may be apparent from birth. On the other hand, temperamental and other environmental factors (e.g., parents, peers) also play an important role in how children regulate their emotions (Morris et al., 2007; Fox &

Calkins, 2003). The behaviour and reaction of parents and peers to socially or emotionally demanding situations, also referred to as social referencing, affect the ability to develop and apply adaptive ER (Fox & Calkins, 2003; Saarni, Mumme, & Campos, 1998).

### *3.6 Family Factors in ER*

Considering the importance of children's ability to manage positive and negative emotions in order to successfully get on with their peers and teachers (Eisenberg et al., 2001b; Ramsden & Hubbard, 2002; Schultz, Izard, & Bear, 2004), it is important to draw attention to the ways that adults socialise children's development of optimal self-regulation (Denham & Grout, 1993; Eisenberg & Fabes, 1992a). The environment in which children grow up has been identified as contributing to the development of emotion understanding. Parental styles, including the communication of emotion, as well as the quality of attachment relationships, and parental education, are important in how children learn to interact with the world around them (e.g., Cutting & Dunn, 1999; Laible & Thompson, 1998; Morris et al., 2007) and so defines what the benefits of applying ER strategies will be (e.g., Campos, Campos, Barrett, 1989; Fox, 1994).

Throughout children's development, primary (problem-focused) and secondary (emotion-focused) coping strategies are used more frequently (Band & Weisz, 1988; Lazarus & Folkman, 1984; McCoy & Masters, 1985; Rossman, 1992). Research needs to focus on the parental involvement in the children's emotional



development, such as fostering the development of emotion knowledge and ER, which both lead to positive outcomes (Southam-Gerow, & Kendall, 2002). It is imperative for parents to help their children label emotions and to talk about them, in particular the less positive ones (e.g., Denham, Mason, & Couchoud, 1995; Dunn & Brown, 1994). Hence, the incorporation of informative parent sessions in early intervention programmes is essential.

Teaching ER strategies is also part of the child therapist's role in CBT. Oppenheim, Nir, Warren, and Emde (1997) showed that the strategies learned can then be applied by the children reducing their levels of SAD or even the risk of developing SAD in the first instance. Therapists are required to apply ER strategies, such as positive thinking, reappraisal, and problem solving, when it comes to feared situations. Moreover, the way in which caregivers express their emotions teaches children a way to learn about their own and other peoples' emotions (Denham & Grout, 1993). Consequently, children who develop higher levels of emotion knowledge and ER are found to present less internalising and externalising difficulties that could result in behavioural problems in school settings (Cole, Zahn-Waxler, Fox, Usher, & Welsh, 1996; Eisenberg et al., 2001b). Accordingly, the greater occurrence of positive emotional expressiveness by caregivers has been associated with higher levels of ER, more adaptive behavioural competence, and fewer behavioural difficulties in children (Denham & Grout, 1993). Equally, research concerning the effect of negative communication from caregivers showed a link to externalising problems (e.g., aggression; Boyum & Parke, 1995; Eisenberg et al., 2001b).

Research has shown that parents who discuss emotions with their children tend to educate them about the implications of emotions, the appropriateness of expression, and the consequences of voicing or not articulating emotions. As a result, those children will have higher levels of emotional understanding and processing (Dunn & Brown 1994; Gottman et al., 1997). Caregivers, for example, who use more socialisation strategies, such as emotion labelling or coaching, contribute to the acquisition of effective ER skills in children (e.g., Ramsden & Hubbard, 2002). Supporting this notion McCoy and Raver (2011) found that both caregivers' expressiveness and the level of ER in children, "contributes to less anxiety, depression, or withdrawal in pre-schoolers, highlighting the importance of examining both child- and family-level factors when considering pathways toward children's behavioural competence vs. difficulty in classroom contexts" (McCoy & Raver, 2011; p. 756). This, in some ways, is consistent as well as inconsistent with past research (e.g., Cole et al., 1996; Eisenberg et al., 2001b). Accordingly, Morris and colleagues (2007) claim the socialisation of the family forms children's expression and regulation of emotion in two ways: firstly, it involves the parents' immediate responses toward their children and secondly, the more general emotional climate to which the child is exposed (Morris et al., 2007). The behaviour of children, their temperament, and their family environment are therefore critical in the prediction of internalising and externalising behaviour.

These findings, together with the aforementioned research, have important implications for preventative interventions to support children. They uphold the incorporation of emotional promoting techniques (supporting emotion knowledge,

adaptive expression, and modulation of negative emotions) and parental education sessions into new or existing interventions to enhance their efficacy. This has been shown to be positively associated with early academic success as well as healthy social and emotional functioning, among other things (Leerkes, Paradis, O'Brien, Calkins, & Lange, 2008). The chapter on emotion knowledge and ER has evaluated this further. Accordingly, the early support in understanding emotions and reacting in an adaptive way is important. This is in accordance with other studies that demonstrated parents' punitive or limited reactions to children's emotional displays of negative emotions to result in maladaptive ER behaviours such as suppression and avoidance (Eisenberg et al., 1998). By the very nature of ER, parents that usually lack positive behaviours in parent-child interactions tend to have children with more inert and controlled responses (Eisenberg, Fabes, & Murphy, 1996b; Feng, Shaw, Kovacs, Lane, O'Rourke, & Alarcon, 2008; Gottman et al., 1996).

Consequently, and considering the importance of ER in social and emotional development, negative parenting reactions to emotions have been shown to contribute to lower levels of social functioning in children (Jones, Eisenberg, Fabes, & MacKinnon, 2002; Fabes, Leonard, Kupanoff, & Martin, 2001). This is in line with findings that support the effects of socialisation on the development of ER abilities (e.g., Tenenbaum, Alfieri, Brooks, & Dunne, 2008). Tenenbaum and colleagues (2008) illustrated the importance of emotion-related vignettes in teaching children about emotions, based on the children's significant improvement in emotion understanding within four weeks. Similarly, pre-schoolers with mothers that respond to their behaviours in adaptive ways, such as by teaching ER strategies, showed

healthier emotion functioning in later childhood. Whereas the children of mothers who mainly modelled rage in response to challenging situations, expressed greater levels of negative emotions and behaviours later in life (Denham et al., 2003). Consistent with these findings, punitive parental reactions to children's emotions not only relate to inappropriate ER strategies (Eisenberg & Fabes, 1994; Eisenberg, Fabes, Carlo, & Karbon, 1992b), but to generally lower levels of socio-emotional competence (Jones et al., 2002).

It should be noted that, despite the various contributing factors in a child's development, the majority of research (with the exception of very few, e.g., Volling, McElwain, & Miller, 2002) has been quantitative and primarily looked into parental influences and mother-child relationships, although research has stated that fathers and siblings also play an important role in children's development of ER (Volling et al., 2002; Zeman Penza, Shipman, & Young, 1997). Thus, the inclusion of all attachment figures as well as other imperative factors, such as parent sessions and qualitative accounts of children might provide further insight into contributing factors with regard to children's emotion knowledge and ER.

### *3.6.1 Children and Parental Emotion Dysregulation*

The dysregulation of emotion is defined in terms of the social context for that emotion. This suggests an emotional response to be inappropriate for a certain context or to interfere with the individual's behaviour and psychological functioning (Cole & Hall, 2008). The number of studies, focussing on ER and emotion dysregulation, is rising and they show that, from a developmental point of view,

patterns of emotion dysregulation can jeopardise or impair functioning, which may result in psychopathology (Cole et al., 1994). In fact, burgeoning evidence has shown that children who show deficits in ER are more vulnerable to internalising and externalising psychological disorders (e.g., Yap, Allen, Sheeber, 2007; Southam-Gerow, & Kendall, 2002). Similarly, McLaughlin and colleagues (2011) state that the dysregulation of emotion serves as a risk factor in adolescent psychopathology. Consequently, the difficulty in regulating negative emotions and poor emotional understanding has been linked to high levels of aggressive behaviour in children (e.g., Calkins, & Keane, 2009) as well as more anxious symptoms (e.g., Suveg & Zeman, 2004).

Developmentally, ER is viewed as an acquired process that emerges primarily within the context of early parent–child interaction (Thompson, 1994). Fundamentally, this capability develops precipitously in infants and young children (Kopp, 1989) and continues to do so throughout adolescence (Zeman, Cassano, Perry-Parrish, & Stegall, 2006). While middle childhood is accompanied by a series of biological, social, and cognitive changes that interact with effective regulatory processes (Zeman et al., 2006) it has been suggested that children’s abilities and ER patterns become more and more independent from parental influence throughout development (Yap et al, 2007; Silk et al., 2003; Zalewski, Lengua, Wilson, Trancik, Bazinet, 2011) making this an important factor to consider for ER. Therefore, it is surprising that research is only recently beginning to pay attention to this developmental phase (Klimes-Dougan, Zeman, 2007).

The majority of available research focussing on familial influences on child psychopathology from the emotional perspective is mostly limited to negative familial experience, such as child maltreatment and parental psychopathology (e.g., Maughan, Cicchetti, 2002; Suveg, Shaffer, Morelen, Thomassin, 2011), or the influence of parental emotion socialisation on child psychopathology (e.g., Chaplin, Cole, Zahn-Waxler, 2005). Although not directly assessed, parents' ER has been stressed to fundamentally explain the impact and mechanisms of emotion-related familial influences. Suveg and colleagues (2011), for example, argued that such associations could be based on the fact that parents with psychological problems tend to experience severe ER difficulties and that such deficits may affect the process and outcome of parental emotion socialisation. This is in agreement with earlier findings suggesting that parental dysregulation of emotion may contribute to poor developmental outcomes for children (e.g., Dix, 1991). Nonetheless, only little research is available that examines the direct link between parental emotion dysregulation and children's development of psychopathology (Garber, Braafladt, Zeman, 1991; Silk, Shaw, Skuban, Olan, Kovacs, 2006; Bariola, Gullone, Hughes, 2011). It is, however, important to keep in mind that not all children whose parents have difficulties in regulating emotions eventually develop similar types of child psychopathology (cf. Han, & Shaffer, 2013). Furthermore, the child's own levels of emotion dysregulation may be a potential moderating factor, yet certain combinations of parental and children's emotion dysregulation patterns could minimise or amplify the risk of children's psychopathological symptoms. Thus, the exploration of possible moderating factors of child emotion dysregulation should be explored further. In addition, many methodological issues regarding the

measurement of emotion dysregulation and ER should be addressed in future studies to enable the most beneficial way of including parents in preventative programmes.

There is ample supporting evidence to show that learning to cope with negative emotions seems more difficult, though more crucial for children, than learning to manage positive emotions (Cole & Hall, 2008; Ramsden & Hubbard, 2002). It is evident that the inability to regulate negative emotions such as anger and sadness may be linked to behavioural and emotional problems (e.g., Eisenberg et al, 2001a; Frick, Morris, 2004; Silk et al., 2003). Given the varying concepts and theories of children's ER in the literature, scientists have begun to apply more person-centred techniques to create a deeper emotional profile (Zalewski et al, 2004; Smith, Hubbard, Laurenceau, 2011). Notwithstanding this new trend, the number of studies adopting such person-centred approaches, by incorporating reports from multiple informants, to study children's ER and emotion dysregulation is rather scarce. However, by including multiple informants, this may not only preclude researchers from drawing conclusions from a single reporter, but also present them with opportunities to make sense of potentially diverging perspectives (Han, & Shaffer, 2013).

One of the studies that has utilised this approach, including parental reports as well as behavioural observations, is by Han and Shaffer (2013). They found that children who adopted a more internalising style in coping with negative emotions reported higher internalising problems when their mothers also experienced higher emotion dysregulation. This suggests that children who may be aware of their own emotional difficulties, but did not express them in ways that were visible to parents

or observers, are at a particular risk in family contexts in which their mothers experienced emotion dysregulation (cf. Han & Shaffer, 2013). However, due to the cross-sectional design of the study, conclusions about the direction of effects cannot be made. Furthermore, the psychopathology of children was only assessed through their parents rather than both through themselves and their parents. Accordingly, qualitative measures may help draw more conclusive findings regarding children's emotional functioning, particularly in challenging situations.

### *3.7 The importance of programmes including ER*

So far it has been demonstrated that research is in agreement about the fact that the adaptive management of emotion is crucial for psychological well-being and social functioning (Aldao et al., 2010; Denham, 1998; Eisenberg, Fabes, Guthrie, & Reiser, 2000a; Gross, 1998b). In early childhood the individual differences in identifying and understanding other people's as well as one's own emotions, are evident. This includes the types of strategies that can be used to regulate them (Denham, 1998; Eisenberg et al., 1993). In turn, these variances have extensive inferences for social functioning (Contreras & Kerns, 2000; Eisenberg et al., 1993, 1997, 2000a; Murphy et al., 2004; Saarni, 1999).

Studies with children and adolescents found that those with higher levels of ER skills are more socially competent, participate in higher levels of pro-social behaviour, are more popular, and have enhanced quality relationships in contrast to youth with lower levels of ER skills. This is also supported to enhance their social competence later in life (Denham et al., 2003; Eisenberg et al., 1995b; Rydell,



Berlin, & Bohlin, 2003; Spinard et al., 2006). By definition, it is therefore crucial for adolescents to be able to successfully regulate emotions produced during interactions with peers (Silvers et al., 2012). Furthermore, research has shown that having ER skills has important implications for an individual's mental health (Gross & Muñoz, 1995; Kashdan & Farmer, 2014). Such findings suggest that there is a link between ER and the development and maintenance of psychopathology in children and adolescents (McLaughlin, & Hatzenbuehler, 2011). In particular, children diagnosed with anxiety disorders have demonstrated poorer emotion knowledge and more challenges in regulating negative emotions than non-anxious youth (Southam-Gerow & Kendall, 2000; Suveg & Zeman, 2004). This is in agreement with other findings suggesting that children who engage in aggressive behaviour are associated with poor emotional understanding and the inability to manage negative emotions (Bohnert, Crnic, & Lim, 2003; Eisenberg et al., 2000a; Shields & Cicchetti, 1998).

Being able to apply ER appropriately supports a range of other important cognitive, emotional, and social processes in numerous circumstances, for example, decision-making, self-esteem, social flexibility and relationships (Cole et al., 1994; Gottman, Guralnick, Wilson, Swanson, & Murray, 1997; Nelson & Guyer, 2011). Throughout middle childhood and adolescence, an increase in ER and greater distinctions of emotional displays occur. These transformations differ according to the type of social context, emotion, as well as a person's motives (Zeman et al., 2006; Zeman & Garber, 1996; Zeman & Shipman, 1997). Past experimental studies have demonstrated that other factors such as temperament, age, gender, and social motivation, have an impact on how a child responds to experimentally manipulated peer feedback. Howarth, Guyer, and Perez-Edgar (2013), for example, revealed

higher levels of sadness in extremely shy boys when the peer whom they wanted to play with rejected them.

Given the importance of social feedback during adolescence, it is indispensable for children and adolescents to develop an understanding of their social relationships, which behaviours, views, and emotions are accepted and preferred by those around them, and how to respond to rejection or an unexpected invitation to a social interaction (Hamm, 2000; Pomerantz, Ruble, Frey & Greulich, 1995). This is closely related to the fact that children build and internalise their self-concept partly through their perception of what others think of them (e.g., self-appraisal; Pfeifer & Peake, 2012). Appraisals as such are valuable considering the increasing awareness in adolescents of being evaluated by others (Sebastian, Burnett, & Blakemore, 2008). Moreover, self-appraisals take more time and energy, being concerned about how they are perceived by others and an individual's social status (Blakemore, Burnett, & Dahl, 2010; Steinberg, 2008). Adrian, Zeman, and Veits (2011) demonstrated that adolescents who were assigned to receive rejection reported a deterioration of mood after receiving negative feedback in contrast to youths who were not rejected. However, after a while, the negative mood improved amongst the rejected children who selected distraction by shifting their attention from negative feelings and distress to positive activities (Reijntjes, Stegge, Terwogt, Kamphuis, & Telch, 2006). Consequently, negative mood states can be improved if children seek active ER strategies. Nevertheless, it seems more useful for children to acquire more antecedent strategies that can be applied prior to receiving and responding to peer evaluation rather than the post-feedback ER strategy as described by Reijntjes and colleagues (2006).

Despite the necessity of adaptive ER, the aforementioned emphasises that the period of adolescence is suggested to be a crucial time to investigate the relationship between ER skills and psychopathology (McLaughlin, & Hatzenbuehler, 2011). Considering the various changes children go through during adolescence, it is crucial that they acclimate a way in which they can deal with emotions successfully in order to ensure adaptive functioning (Larson & Richards, 1991). If this does not occur those children who are unable to regulate destructive emotions, proceeding from the various demands of adolescence, may be at particular risk of developing mental health problems (Silk et al., 2007). In the face of these significant results, most of this research has been cross-sectional in nature. However, there have been some noteworthy exceptions where, specifically, rumination has been focussed on (Broderick & Korteland, 2004; Burwell & Shirk, 2007), and problem behaviours in young children (Eisenberg et al., 2000b). This raises the question, whether the inability to apply ER presents a risk factor for the development of mental health problems in children, or whether the onset of adolescent psychopathology leads to the inability to effectively apply ER. In case of the latter (ER as a consequence of mental health problems) techniques supporting ER skills should be incorporated into treatment rather than prevention, whereas the former (ER as a risk factor for future mental health problems) suggests that such supporting techniques should be integrated in both treatment and preventive interventions.

The study by McLaughlin and Hatzenbuehler (2011) is one of the very few, to date, that challenged this issue and noted that deficits in ER predicted changes in various pathologies except depression, whilst psychopathology did not predict alterations in emotion dysregulation. This supports the notion that deficits in ER are

a predictor rather than a consequence of adolescent mental health problems. It has been argued however, that the awareness of emotions is required in order to enable the adaptive regulation of emotion (Saarni, 1999), and that accordingly, poor awareness has been associated with deprived mental health outcomes (Mennin et al., 2009; Novick-Kline, Turk, Mennin, Hoyt, & Gallagher, 2005; Southam-Gerow & Kendall, 2000; Suveg & Zeman, 2004). This is in line with McLaughlin and Hatzenbuehler (2011) and calls for future prevention and intervention programmes to include both emotion knowledge and ER enhancement strategies.

The findings by McLaughlin and Hatzenbuehler (2011) further support the notion that adolescents, who have a better understanding of their emotional experiences, are usually more expressive of their emotions and present more adaptive ER strategies. This coincides with earlier findings, suggesting that the comprehension of one's own emotions is crucial for the adaptive expression and regulation of emotional experiences (Saarni, 1999). Overall, the studies on ER and psychopathology in children agree that deficits in ER are a fairly universal risk factor for various psychological disorders (Aldao & Nolen-Hoeksema, 2010; Aldao et al., 2010; Gross & Muñoz, 1995; John & Gross, 2004; Mennin et al., 2005; Moses & Barlow, 2006). In particular, the findings by McLaughlin and Hatzenbuehler (2011) mirror findings from other cross-sectional studies demonstrating deficits in ER in youths with anxiety disorders (Southam-Gerow & Kendall, 2000; Suveg & Zeman, 2004), problematic aggressive behaviour (Bohnert et al., 2003; Dearing et al., 2002), and eating disorders (Sim & Zeman, 2005, 2006). According to the authors, techniques aiming at "increasing emotional awareness and understanding, effectively managing expressions of sadness and of anger, and reducing engagement in

rumination could, in particular, improve the efficacy of preventive and treatment interventions” (McLaughlin & Hatzenbuehler, 2011; p. 22). Therefore, the inclusion of ER skill enhancement in CBT intervention programmes may support significant improvements in an individual’s mental health (McLaughlin & Hatzenbuehler, 2011). In line with this, a study by Watkins and colleagues (2007) that implemented traditional CBT techniques, including functional analysis to detect and reduce engagement in rumination and problem solving thinking styles, found significant reductions in depression.

Based on these findings the current research is trying to incorporate methods that endorse emotional understanding and adaptive ER strategies to enable the adaptive management of negative emotions. Furthermore, the intense changes that have been reported in the quality and quantity of ER during preschool- to school age transition (3-6years of age approximately) highlight the importance of early attendance to the concept of ER (Calkins & Marcovitch, 2010; Kopp, 1989). The regulation of emotions becomes more complex during this time due to the increased sense of self-awareness in children (Kopp, 1989). In view of the fact that, as social demands increase, and as children mature, the necessity of more ER abilities rises (Losoya, Eisenberg, & Fabes, 1998). This, again, underlines the importance of programmes that include the development and maintenance of ER strategies. The review by Losoya and colleagues (1998) demonstrated the diverse use of ER in children between ages 4–6 to ages 6–8. According to the studies the authors reviewed, avoidance as a strategy for coping with negative emotions increased linearly with age. Additionally, more cognitively complex and inner-focussed strategies such as aggressive coping and venting seemed to increase with age,

whereas the more effective strategies for managing negative emotions included positive cognitive restructuring and seeking support from others, all behaviours related to positive social functioning (Losoya et al., 1998). Nonetheless, children who present an inability to regulate emotions effectively, and subsequently develop maladaptive strategies for regulating negative emotions, seem usually at risk for psychosocial maladjustment.

With regard to ER and SAD, research has shown that individuals diagnosed with SAD constantly repeat and review negative aspects of their performance after they have been confronted with an anxiety-provoking social situation, also referred to as post-event processing (Clark & Wells, 1995). As previously outlined, Clark and Wells (1995) suggest that socially anxious individuals repeat the social event in their minds in a negative way. This, in turn, enhances the individual's negative beliefs, negative emotions, and misinterpretation of social situations. As a result, SAD is maintained. This process has also been referred to as post-event rumination (Abbott & Rapee, 2004; Edwards, Rapee & Franklin, 2003). This is in line with studies that have shown the engagement of elevated levels of post-event rumination in individuals with SAD (Abbott & Rapee, 2004; Brozovich & Heimberg, 2008). The link between post-event rumination, negative self-appraisal of performance, and elevated SAD, calls for more adaptive regulation strategies to be taught (Rapee & Abbott, 2007). Moreover, other underlying concepts, such as the perception of performance, may play a role in the relationship between SAD and post-event rumination (Perini, Abbott & Rapee, 2006).

Previous research has further highlighted the influential role selective attention plays in the development and preservation of SAD (Bögels & Mansell, 2004; Spurr & Stopa, 2002). According to Heeren, Reese, McNally Keehn, and Philippot (2012), biased self-focused attention can be modified through redirecting the individual's concentration on internal interpretations, which is therefore a vital component in the treatment and prevention of SAD. It would be advantageous to future treatments to further the understanding on maladaptive regulation strategies such as post-event rumination or suppression. Investigating responses, by discriminating according to the type of socially and emotionally challenging situation will assist in formulating more specific and beneficial strategies that can be taught. Thus, the present research will contribute to existing literature through qualitative, first-hand accounts from children on demanding situations.

### *3.8 Summary of the critical evaluation of past research on SAD, ER, and CBT*

#### *Programmes*

Table 2.2 summarised CBT-based programmes that focused on the reduction of SAD, amongst others. The studies evaluated in chapter 3 concentrated on programmes that included ER components. To our knowledge, no programme, thus far, has combined both successful factors in the prevention of SAD. Although research has argued that ER components are part of CBT (Butler, Chapman, Forman, & Beck, 2006; Fresco et al., 2013; Hollon, Stewart, & Strunk, 2006), the inconclusive findings call for more refinement in combining these mechanisms. Furthermore, most of the existing research has focussed on anxiety disorders in

general, utilised a clinical sample, employed a more interventionist rather than preventative approach, and applied a solely quantitative method. Consequently, programmes addressing these issues are crucial, especially considering the increasing numbers of children diagnosed with SAD (DSM-5; APA, 2013; Essau et al., 1999; Hitchcock et al., 2009).

Following the aforementioned, there is no uncertainty about the importance of prevention and intervention programmes for children from as early an age as possible. To recap, prevention programmes are put in place before disorders have developed in order to enhance protective factors or reduce risk factors of developing disorders (Crill Russell, 2003; Mzarek, & Haggerty, 1994; Shonkoff, & Philipps, 2000). On the other hand, intervention programmes are more targeted and take place once a diagnosis has been made. Furthermore, treatments that focus on individuals and diagnose samples are usually quite costly and are not necessarily accessible, which could explain the low utilisation rate by parents with children who suffer from SAD (Albano et al., 2003; Bögels et al., 2001; Essau, 2005; Hope, Heimberg, & Turk, 2006; Magee et al., 1996; Offord et al., 1998; Olfson et al., 2000; Ruscio et al., 2008). Thus, a prevention programme could enhance the utilisation and earlier attention to children at risk (cf. Felner et al., 1993; Cognitive-Behavioural Stress Management, CBSM, Hains, 1992; FRIENDS, Lowry-Webster et al., 2001; Lowry-Webster et al., 2003).

In particular, the FRIENDS programme used cognitive behavioural techniques in order to educate children about the way in which to apply problem solving as well as relaxation skills, so as to manage feelings of worry and anxiety.



The FRIENDS programme looked at a mixed gender sample aged 10-13 years including parents' involvement during the 10-week programme. The results revealed improvements of anxiety and depressive symptoms, with the results being strongest for children with high levels of anxiety at pre-test. These findings were maintained at 1-year follow-up. Despite the success of available prevention programmes the findings are limited to clinical samples and not specific to SAD. Additionally, cross-sectional research designs in some cases, inappropriate control groups or small sample sizes present methodological inconsistencies that need to be addressed (Baer, 2003; Kotsou et al., 2011). However, it is noteworthy that employing large sample sizes may be limited in meeting participants' varying needs.

Nevertheless, many of the existing studies further seem to assess the participants' levels of (S)AD and ER through mainly quantitative measures, which could be criticised for assessing these factors hypothetically rather than genuinely (Campos, Walle, Dahl & Main, 2011). Moreover, self-report measures may be affected by response bias or recall deficiencies, which all limit the inherent validity of the findings. Finally, the components involved in most existing programmes for SAD in children usually focus on generic CBT or ER strategies rather than paying attention to both problem- and emotion-focused strategies to gain the utmost health benefits (Lorig & Holman, 2003).

## Chapter Four: Synopsis of Thesis

### *4.1 Prerequisites of Current Research*

The justification for this research is based on the limited availability of observational studies including various measures and of a paucity of psycho-educational programmes for children that could aid the prevention of psychological disorders, such as SAD, as well as a qualitative approach to this matter. It further makes a unique impact to the theoretical domain of ER and CBT research when it comes to the possible prevention of SAD and it can, therefore, contribute to existing knowledge through its practical and theoretical benefits. Firstly, the present project utilised, substantial sample sizes in all studies. Secondly, it applied subjective as well as objective measures in both quantitative and qualitative ways. Thirdly, it combined successful components such as CBT and ER, employed an active control group and a three-month follow-up measure in the second study. Fourthly, it evaluated the role of ER further in the third study through qualitative interviews, investigating the personal experiences of children and their parents in demanding situations. The preventative nature of the current studies and the findings obtained could aid existing programmes to prevent and reduce the number of children developing SAD.

#### *4.1.2 The Scientific and Social Need*

SAD is becoming a more prevalent and severe psychological disorder in young children and the dysregulation of emotions has shown to be closely related to its symptomatology. Whilst existing research indicates that CBT approaches may be successful in initial treatment, individuals continue to maintain significant levels of

anxiety in the long term (Brozovich & Heimberg, 2011; Cartwright-Hatton et al., 2004; In-Albon & Schneider, 2007). Furthermore, findings indicate that children with SAD benefit less from common anxiety treatments compared to children with other forms of anxiety disorders (Ginsburg et al., 1998; Hudson, Rapee, Lyneham, Wuthrich, & Schniering, 2010).

The literature review has provided a comprehensive picture of the severe consequences that SAD has on various aspects of an individual's life (e.g., functional impairment, Bruch et al., 2003; Wittchen et al., 1992; social skills impairment, Alfano et al., 2006; Beidel et al., 1994; cognitive impairments, Kanai et al., 2009; Tuschen-Caffier et al., 2011). In addition, the early onset of SAD (Beidel & Turner, 2007; Dalrymple et al., 2007), its high occurrence (e.g., Hammerness et al., 2008), the extensive cost mental illness, in general, has on the economy (e.g., Acarturk et al., 2009), the rather low utilisation rate of programmes that treat or prevent SAD, in the first instance (e.g., Albano et al., 2003; Essau, 2005; Hope et al., 2006; Masia-Warner et al., 2005; Ruscio et al., 2008), as well as the existing limitations of the available (treatment) programmes, stress the need for improvements or generally the development of more successful psycho-educational programmes that are more accessible, affordable, and effective in the long run.

Despite various successful programmes (Baer & Garland, 2005; Gallagher et al., 2004; Kley et al., 2012), the majority of available research has examined treatment and intervention programmes with clinical samples and in a quantitative fashion as previously outlined in more detail (e.g., Baer et al., 2005; Gallagher et al., 2004; Masia et al., 2001; Shortt et al., 2001). In part these limitations are due to the

fact that many practitioners and researchers are attending to the increasingly important matter of early onsets of mental illness and considering the variety of the existing disorders rather than specific ones (Barrett, 1998; Crawley et al., 2012; Shortt et al., 2001). Notwithstanding the importance of attending to clinical samples, it is crucial to focus on preventative programmes, more so, in order to reduce the development of psychological disorders in the first instance (Crill Russell, 2003). The development of a prevention programme, incorporated in school curriculums, that includes other relevant components such as ER could, therefore, reduce the onset of SAD in children in the first place (Collins et al., 2013). In addition, qualitative research methodologies applied in the field of SA and ER in children can enhance our understanding of both phenomena together with the contributing factors. It is, thus, possible to support the development of more successful programmes, reducing the onset, as well as the maintenance of SAD and maladaptive ER, that have been associated with many other psychological disorders (Bender et al., 2012; McLaughlin & Hatzenbuehler, 2011). Through an advanced and more in-depth account of socially and emotionally overwhelming situations and contributing factors, the development of more successful intervention and prevention programmes can be facilitated.

Considering the importance of ER in treatment and prevention programmes, as outlined in the literature review, it is rather surprising that research including a community sample and a qualitative approach, is scarce. Available research has clearly indicated that the involvement of ER has shown strong preventative properties as it serves as a protective factor against psychological disorders, such as

depression (Deyo, Wilson, Ong, & Koopman, 2009; Joormann & Vanderlind, 2014) and SAD (Clerkin & Teachman, 2010; Suveg & Zeman, 2004). Moreover, studies have shown that programmes including such strategies are successful in enhancing ER competencies and reducing levels of anxiety and as a result improve personal relationships (Collins et al., 2013; Izard et al., 2008; Mennin & Fresco, 2009). However, most of these studies are limited to clinical samples and specific coping strategies.

Consequently, and considering past literature, which looked into the positive effects of emotion control (explained further in chapter three), the present study will extend on these findings by examining the impact of CBT and ER through a brief programme based on CBT, focussing on emotion and social enhancement skills to reduce levels of SA. It could help children going through transitions and particularly at the time of development, when they become more conscious about themselves and how others might perceive them. Additionally, it will help to develop emotion resilience as well as social skills, and with that perhaps prevent disorders such as SAD and enhance children's self-esteem. The current programme attempts to enable and enhance the utilisation and earlier attention to children at risk as well as to address the limitations of previous studies in this field. Therefore, a CBT-based, social and emotion regulation skill enhancement programme may offer a valuable alternative in the prevention of SAD. The preventative nature of the ESST-C is designed to minimise the number of children meeting criteria for a clinical diagnosis (Barrett et al., 1996; Kendall, 1994) by including other relevant components such as ER. Thus, the current study is aiming to take the initial step towards identifying

relevant factors that should be included in programmes that could prevent the onset and/or maintenance of SAD and the enhancement of ER.

#### *4.2 Research Strategy*

The following will present the way in which the elaborated literature has informed the research strategy employed within this thesis. Considering the severe consequences of SAD and the importance of ER strategies, the necessity of prevention programmes focussing on reducing levels of non-clinical SA and enhancing levels of ER is evident. Correspondingly, the limitations of CBT treatments and existing programmes discussed in the literature review, call for the inclusion of other relevant aspects combined with CBT in the prevention and treatment of SAD. According to Webb, Miles, and Sheeran (2012) individuals vary in their levels of ER. This is due to the range of factors, such as the dynamic nature of emotions themselves, as well as personality and individual differences, which possibly predispose individuals to use certain strategies over others. However, to our knowledge, no qualitative study thus far has examined this matter. Children, in particular, are most often not even aware of available ER strategies due to their limited knowledge and understanding of emotions themselves.

The first study, therefore, aimed to present the relationship between SA and ER, as well as the negative consequences that are present in non-clinical SA, which could ultimately lead to clinical SAD. Accordingly, the second study included necessary components into a newly developed, multifaceted prevention programme that focussed on the reduction of elevated levels of SA and enhancement of ER

skills. In accordance with Gross and Thompson (2007), the proposed prevention focussed on enabling children to cognitively reappraise challenging situations. This is done by improving children's awareness of their emotions and enabling them to identify and then regulate them, when necessary, from an early age (Gross, 1998a). In addition, the refinement of particular social skills was targeted (e.g., Berking & von Känel, 2007). It is important to teach children at what stage and how to use different social skills and ER strategies to reduce the risk of developing and/or maintaining SAD (Berking et al., 2008; Mennin, 2006). Considering the importance of self-talk on human functioning (Brinthaup, Hein, & Kramer, 2009), for example, the current programme applies sessions on self-talk where children are taught to recognise the different ways of dealing with unhelpful thoughts as well as emotions (Burns, 1989). Moreover, the sessions include focussing on personal strengths, achievements and preferences to elevate positive affirmation statements and thoughts that can be applied in times of distress. In addition, the second study incorporated parents and teachers reports and employed a community sample, looking at post-programme assessments in conjunction with a three-month follow-up to ensure that there has been sufficient time to consume, understand, and apply acquired skills learned during the programme. The ESST-C is based on the CBT principles employed in FRIENDS, while mainly focusing on non-clinical childhood SA. In order to enable continued delivery of the programme, enhance preventive measures in schools, and to reduce significant costs prevention programme usually encounter, the current study has therefore allowed classroom teachers or associated staff (e.g., Special Educational Needs Coordinator, SENCO) to participate in a CBT workshop and to shadow the delivery of the ESST-C. Lastly, the benefits of qualitative

research, which allows a more in-depth analysis and evaluation of a certain domain, was considered important, in order to expand our knowledge in this research area. Thus, the third study emerged.

In order to explore the role of ER in SA in children, the present project utilised an observational study and an exploratory study with a longitudinal research design that employed a control group and follow-up assessments, as well as a qualitative research design for the final study. It is hoped that the current research will, thus, aid the development of more suitable and beneficial prevention programmes. In addition, the present thesis is able to attend to a variety of research questions regarding SA and ER by applying mixed methods. Consequently, it can increase the generalizability of the results and produce a more complete understanding to inform theory and practice.

#### *4.3 Aims and Objectives of the Current Research*

The majority of available therapies and intervention programmes focus on the treatment of SAD rather than the prevention of it. This highlights the importance of the latter. In addition, no research to date appears to have conducted a qualitative study to gain a deeper understanding of how socially and emotionally challenging situations are perceived by children, thereby shedding light on important treatment components. Consequently, the purpose of the current research was to explore the factors that could aid the reduction of SA and possibly prevent SAD by (1) exploring in more depth the consequences of SA as well as emotional and behavioural difficulties on performance situation and to assess the relationship between SA, ER,



and self- and observer-ratings, (2) to examine the feasibility and effectiveness of the newly developed programme, based on the findings of Study One and the successful application of CBT and ER principles. In addition, the present intervention intends to focus on antecedent ER strategies, and on enhancing emotion knowledge in children, by, among others, utilising the process model of ER (Gross, 1998b). This is exclusive to the current training programme, since existing programmes tend to adopt one or the other, rather than both, the adoption of successful ER strategies together with the recognition and identification of emotions. Particular emphasis is placed on prevention, in accordance with other components of CBT. It is essential to concentrate on the psychological dysfunction, whilst including the amendment of behavioural tendencies that derive from emotion dysregulation, as well as including the process of reducing maladaptive thoughts and feelings, to prevent avoidant behaviour (Moses & Barlow, 2006); (3) to explore children's personal accounts of socially and emotionally challenging situations together with their parents experiences of these, in order to achieve further clarification on the role of ER and other contributing factors. The outcomes could aid refinements of existing programmes and the development of particularly beneficial prevention programmes.

## **Chapter Five: Study One**

### **The Exploration of Social Anxiety and Emotion Regulation in Children's Performance**

#### ***5.1 Overview***

This Chapter aims to present an observational study exploring the effects of elevated levels of SA and reduced levels of ER on participant children's performance. This was conducted to address some of the issues and inconsistencies identified in the existing literature that will be outlined further in the section below. A quantitative method with a behavioural and observational component was utilised to determine the effects of SA and ER on performance and self-perception with 8-11 year old children, their respective teachers, and parents.

#### ***5.2 Introduction***

In relation to SAD, the majority of available observational and behavioural studies have yielded inconsistent results, with regard to physiological symptoms (e.g., somatic discomfort, such as blushing), behavioural factors (e.g., social skills, including eye-contact, conversation flow, etc.), and cognitive components (e.g., speech disturbances, self-perception biases). Considering the fundamental fears of children with SAD, a performance-speaking task within the school environment, in front of other peers and adults, may provide an ideal exposure task to investigate various factors of non-clinical SA (e.g., Rao et al., 2007). These include aspects such as gaze, vocal quality, length of speech, discomfort, conversation flow, and self-perception biases. Available research, looking into somatic reactions, of individuals diagnosed with SAD support the notion that blushing, for example, is related to

levels of SAD (e.g., Bögels, Rijsemus, De Jong, 2002; Hofmann, Moscovitch, & Kim, 2006), although others found contradicting results (e.g., Drummond et al., 2007; Edelman & Baker, 2002). Thus, there is conflicting evidence as to whether individuals with SAD blush more frequently or more intensely than their counterparts, indicating different levels of discomfort. Similarly, findings regarding eye contact and speech disturbances present discrepancies.

The first study to examine differences in gaze behaviour and speech disturbances during public speaking based on SAD subtype was by Hofmann and colleagues (1997). Their findings revealed eye fixation in social situations and speech disturbances to be rather unintentional or automatic and suggested that this may reveal suppressed emotions. According to the authors the aversion of gaze is a sign of social fear and speech disturbances are indicated through an interruption or blockage of a train of thought. The way in which they are usually presented is through silent pauses or pauses including utterances like “mm,” “hum,” etc., “which include sentence change, repetitions, stutter, omission, sentence incompleteness, tongue slips, and intruding incoherent sounds” (Kasl & Mahl, 1965; Mahl, 1956, 1987, as cited in Hofmann et al., 1997; p. 574). On the contrary, the findings by Stopa and Clark (1993) showed that individuals diagnosed with SAD tend to speak fast and avoid pauses during their speech as they do not want to come across as boring or anxious and think that they would, if they paused or talked slower.

More recent findings regarding atypical gaze suggested an association with higher SAD (Horley, Williams, Gonsalvez, & Gordon 2004; Moukheiber et al., 2010) and for gaze to serve a crucial role in social functioning (Dalton et al., 2005;

Jawaid, Schmolck, & Schulz, 2008). In line with this, Schneier, Rodebaugh, Blanco, Lewin, and Liebowitz (2011) found individuals with higher SAD to report greater fear and avoidance of eye contact. Interestingly, Hofmann and colleagues (1997) did not find gaze behaviour to be a conclusive gauge for anxiety in their task. While a significant difference was recorded between subjective anxiety, there was no difference in gaze behaviour, although participants reported higher mean eye-contact duration during a speech performance rather than from a conversation task. These results are inconsistent with earlier (e.g., Jurich & Jurich, 1974), as well as more current findings (e.g., Langer & Rodebaugh, 2013) which may be due to methodical differences such as allowing participants to refer to notes during their speech or letting them talk about rather provoking topics that can create shame over anxiety and lead to a difference in gaze behaviour.

The study by Langer and Rodebaugh (2013) showed that gaze avoidance is related to increased anxiety, over time, for those with higher SAD, even in relatively positive social encounters. This finding is in line with previous results on safety behaviours such as hiding anxiety, which tends to maintain anxiety over time (e.g., McManus et al., 2008; Moscovitch 2009; Plasencia, Alden, & Taylor, 2011). Notwithstanding from the outcomes that highlight significant differences in behavioural measures, others are controversial particularly with regard to SAD (Beidel, Turner, & Dancu 1985; Rapee & Lim, 1992; Strahan, 1998). Deriving from these discrepancies Hofmann and colleagues (1997) decided to examine differences between socially anxious and non-anxious individuals and within SAD subtypes in non-verbal behaviour. Their findings suggested individuals diagnosed with

generalised anxiety to report high levels of anxiety during public speaking as opposed to non-generalised controls. All participants showed more frequent and longer eye contact during their speech as opposed to during their talks with the experimenter or in front of an audience. Furthermore, in line with other studies (e.g., Lewin, McNeil, & Lipgson, 1996), controls exhibited shorter silent intermissions, and less frequent pauses compared to the phobics when giving a speech. These results are, however, in contradiction to Stopa and Clark (1993) and further suggest that individuals diagnosed with generalised anxiety have the tendency to divert their attention from the production of discourse to other mental tasks (Hofmann et al., 1997). Considering that the production of speech involves numerous and complex cognitive processes that demand a specific amount of attention, this can be extremely challenging in socially anxious individuals. These individuals tend to divert their attention to other cognitive processes such as their presence, feelings, and attributes during a speech and the way they come across to the audience rather than what they are saying (Daly, Vangelisti, & Lawrence, 1989). As a result, public-speaking tasks provide a perfect exposure task to study a variety of SA measures.

The majority of findings are in agreement that the self-representational beliefs of individuals diagnosed with SAD inhibit their speech quality (Hofmann et al., 1997; Lewin et al., 1996). Conversation flow and gaze, fluency in speech, as well as reasonable levels of nervousness about speaking publicly have been considered central for a successful performance (Starcevic, Ljubomir, Kelin, & Markovic-Zigic, 1994). The study by Mallott, Maner, DeWall, and Schmidt (2009), which included a few additional behavioural measures, concluded that individuals high in SAD

demonstrated poorer vocal quality, eye contact, and gaze quality in contrast to low socially anxious participants. However, their speech task contained an interaction with someone after a different partner rejected them, which could have been an influential factor in these results. Nonetheless, the authors concluded that these behaviours could effectively preserve the cycle that maintains presented performance difficulties in individuals diagnosed with SAD. Thus, these findings highlight the importance of addressing such challenges and support earlier studies suggesting that gaze alone does not demonstrate differences in socially anxious versus non-anxious individuals (Beidel et. al., 1985; Glasgow & Arkowitz, 1975). As a result, it seems important to include a number of variables to be measured when analysing performance tasks. Thus far, studies have only used limited numbers of particular measures, clinical and somewhat small sample sizes, and focused merely on adults. Hence, the current study examines the behavioural differences between high vs. low SA in a community sample of 64 children including a number of social behaviour measures (gaze, vocal quality, length of speech, discomfort, and conversation flow, as adapted from Fydrich et al., 1998). Moreover, whether there is a significant difference in self-perception between these participants as measured by SA, ER, and a Performance Questionnaire, will be investigated.

It is proposed that the perception of the self is a crucial aspect in individuals diagnosed with SAD. Research that has focussed on the cognition of individuals diagnosed with SAD has shown that these individuals have a predisposed perception of the way they appear socially (Rapee & Lim, 1992; Stopa & Clark, 1993), while overestimating their anxious presence and underrating the quality of their social

behaviour (Clark, 2001; Clark & Wells, 1995; Rapee & Heimberg, 1997). This has been highlighted by existing literature that found that individuals diagnosed with SAD have biased and more negative perceptions of their social performance, which is usually evaluated through the inconsistencies between participants' and observers' ratings (e.g., Strauman 1989). Research suggests including participants' views on how they expect to be seen by others during a performance task, since the possibility remains that living up to perceived standards of others is related to SAD (Voncken & Bögels, 2008). The study by Voncken and Bögels (2008) examined whether biased self-perception or the actual social performance deficits characterise SAD. The authors examined conversation as well as speech tasks, assessing both anxious appearance and social behaviour. Interestingly, their findings showed that individuals with SAD underrate their performance predominantly during a speech rather than a conversation as opposed to controls. Furthermore, participants demonstrated actual performance problems during conversations, but not during speeches, in contrast to the participants in the control group. However, the findings of this study are limited to a clinical, adult sample and it remains unclear whether these findings remain in a non-clinical and younger group sample. In addition, the findings rely on an artificial social task, which means participants may have reacted differently in real life situations.

Consistent, however, with cognitive and interpersonal models of SAD (Alden & Taylor, 2004; Clark & Wells, 1995; Hofmann, 2007; Rapee & Heimberg, 1997), several studies argued that patients with SAD perceived themselves as being socially undesirable in contrast to others. Existing literature has shown that individuals high

in SAD rate themselves more negatively when evaluating their own social performance and personality attributes, even when their interactions are objectively successful (e.g., Alden, Mellings, & Ryder, 2001; Alden & Wallace 1995; Moscovitch & Hofmann 2007; Moscovitch et al., 2009; Stopa & Clark 1993; Wilson & Rapee 2006). Furthermore, studies have found physical and behavioural impairments in individuals with heightened levels of SAD, which in turn could lead to the maintenance of SAD (e.g., Mallott et al., 2009; Voncken & Bögels, 2008).

Despite the biased self-perception in social tasks, some research has shown poorer performances in individuals diagnosed with SAD, when compared to participants in the control group (e.g., Beidel et al., 1985; Thompson & Rapee, 2002) and clinical samples (Baker & Edelmann, 2002; Fydrich et al., 1998; Stopa & Clark, 1993). However, it remains unclear whether individuals diagnosed with SAD are characterised by their biased self-perception or their actual performance discrepancies. Most of the studies that supported the notion of social performance deficits in participants with SAD, failed to clarify whether these deficits were a result of social behaviour, appearing anxious, or both. In other words, most assessment measures contain physical symptoms such as blushing, trembling, sweating, looking nervous, which could be argued to present a deficit in social behaviour. However, they are physiological reactions, which are unconscious and not under voluntary control, as opposed to conscious social behaviours. This is in accordance with Bögels and colleagues (2002) who established anxious appearance to be distinct from social behaviour in panel observations of participants during a social conversation. In line with these findings, further research established that



individuals high and low in SAD could be differentiated by an anxious appearance, rather than by social behaviour (Bögels et al., 2002).

Research has indicated the importance of distinguishing between speech- and conversation tasks when examining social performance deficits. For example, while some studies have not found a difference in social performance in individuals with SAD (e.g., Rapee & Lim, 1992), others demonstrated performance deficits during conversation tasks in individuals diagnosed with SAD (Alden & Wallace, 1995; Baker & Edelmann, 2002; Stopa & Clark, 1993). This may be due to the fact that conversations are more intricate than individual speech tasks. To illustrate, interactions with more than one person can be more complex and require a division in attention. The cognitive problems may then increase due to the complexity of the social task that could, in turn, intensify social performance difficulties. This was supported by the findings of Voncken and Bögels (2008), whereby individuals with SAD displayed social performance deficits, except in speech tasks. Contrastingly, earlier findings by Hofmann and colleagues (1997) concluded that individuals diagnosed with SAD paused more during a speech than their counterparts in the control groups. These differences could be based on the nature of the task, as Thompson and Rapee (2002) clarified SAD patients present more impairments during unstructured rather than structured conversation.

To clarify, while a speech requires action solely from the speaker, a conversation requires interaction, which could be quite unpredictable and therefore less structured. Additionally, the participant is more in control over a speech than a conversation, as nobody talks back. However, school children in particular are often

exposed to performance situations, where they have to give a speech. According to research, this is one of the most feared aspects of individuals with SAD (e.g., APA, 2013; Essau et al., 1999, Rao et al., 2007) highlighting the importance of such tasks to explore relevant programme components for the treatment and prevention of SAD.

Taken together, some inconsistencies remain and may depend on different approaches to the actual performance task. As research has shown, many behavioural deficits are present in individuals with SAD when giving a speech. It would therefore be interesting to see whether this is the case in a community sample of children with heightened levels of SA. Findings by Cartwright-Hatton and colleagues (2003) demonstrated only a modest correlation between SPAI-C scores and total objective performance, indicating the level of performance to be independent of SAD levels. The authors concluded that many of the socially anxious children are not lacking the social skills necessary to perform well on this public speaking task. The children's self-ratings on their performance was associated with their degree of symptomatology, as children with severe SAD rated themselves worse than children with less severe SAD. Conversely, this was not the case for the observer ratings, which led the authors to conclude the difficulty of children with state anxiety to lie in their self-perception rather than their actual abilities. Accordingly, social skills deficiencies may not be the cause for SAD in children, although the lack of these abilities in individuals diagnosed with SAD (Alden & Wallace, 1995; Creed & Funder, 1998; Meleshko & Alden, 1993) can lead to unpopularity. This, in turn, can maintain SAD and impacts upon the general well-

being of a person (see the review of Alden & Taylor, 2004). It appears crucial to extend these findings by assessing whether or not behavioural deficits are apparent in a community sample of children with higher levels of SA and lower levels of ER.

### *5.3 Rationale and Objectives*

Considering the aforementioned, surprisingly, little attention has been paid to the negative consequences of elevated, non-clinical SA and low or non-existent ER through subjective as well as observational measures that assess children's behaviour of social performance. Further clarification of the difficulties experienced in community samples can help prevention programmes to include beneficial components in order to reduce the risk of developing SAD in the first place. Considering children are exposed to various performance situations in schools, it is essential to examine the negative impacts elevated levels of SA, behavioural difficulties, and low levels of ER have on children's performance, as this may lead to the maintenance of SA and possibly the development of SAD. However, the majority of studies available, that tested performance situations, usually employed clinical, adult samples, limited behavioural measures, and/or interaction tasks, which restrict the findings to those groups. To our knowledge, no study so far has examined a variety of behavioural measures in a non-clinical child population over the period of two minutes, divided into four parts and including self- as well as panel ratings. The current study included the self-ratings of children before and after the task, the ratings of the panel during the task performance, as well as the available data on the children's levels of SA and ER. The findings could support previous conclusions on

the negative consequences of SAD on an individual's performance, which may maintain the biased self-perception in individuals diagnosed with SAD.

The first study involved the assessment of SA, behavioural difficulties, and ER with regard to performance situations and self-perceptions. The aim was to address the inconsistencies regarding the functional impairments of SAD in performance situations. This is crucial, considering the importance that cognitive models of SAD have placed on self-perception as a crucial factor in the maintenance of this disorder (Clark, 2001; Clark & Wells, 1995; Leary, 2001; Rapee & Heimberg, 1997). Therefore, this study contained observational, behavioural, as well as self-report measures to add to the consistency and reliability of the findings. Participants were exposed to a two-minute speech task in front of a small group of children, two-person panel, and a camera. The variety of measures obtained was based on quantitative self- and observer-ratings, as well as the later video analysis by two collaborators.

The main objective of the present study was therefore to investigate the relationship between SA and ER and self-and observer-ratings (through the Performance Questionnaire (PQ-C) and the Objective Performance Questionnaire (OPQ-C)). Furthermore, the aim was to explore the difference between self- and observer-ratings in order to test biased self-perceptions in children with higher levels of SA and lower levels of ER (through PQ-C and OPQ-C). Lastly, this study intended to determine the negative consequences of heightened levels of SA (through the Social Phobia and Anxiety Inventory for Children (SPAI-C)) and behavioural difficulties (through the Strengths and Difficulties Questionnaire (SDQ))

on performance measures (gaze, vocal quality, length of speech, conversation flow, discomfort) over time (through the Speech Performance Rating Scale (SPRS)) in a non-clinical population of children.

Hypotheses:

- (1) There is a significant positive correlation between SA and PQ-C (children's self-perception) and a significant negative correlation between ER and PQ-C, and ER and OPQ-C (observer perception).
- (2) There is a significant difference between the self-ratings (PQ-C) of children with higher levels of SA and lower levels of ER and the observer ratings (OPQ-C).
- (3) There is a significant difference in various performance measures (gaze, vocal quality, length of speech, conversation flow, discomfort) over time (2 minute performance) between different levels of SA and behavioural difficulties.

## *5.4 Methodology*

### *5.4.1 Design*

This study utilised a quantitative method with a behavioural/observational component to determine the effects of elevated SA and levels of ER on performance and self-ratings. Participants' levels of SA and ER were assessed at baseline and their self-rating was measured before and after the speech task. The recorded speeches were then analysed by two Psychology graduates. For the purpose of the study, a number of Analyses of Variance (ANOVA) were conducted as well as correlation analyses to assess the relationship between SA, ER and self- and observer-ratings. This study used a randomised convenience sample.

### *5.4.2 Ethical Considerations*

Prior to the commencement of this study, ethical approval was obtained from the Ethical Board of the University of Roehampton (Appendix I). After ethical approval was acquired, schools were invited to participate in this study. The schools interested in taking part invited parents and children to participate in this study via the school's newsletter. Those parents who volunteered for the study were provided with a letter of invitation explaining the project (Appendix II) followed by a consent form, which they were asked to complete for themselves and their children (Appendix IV). The form explained the primary objectives of the study in order to obtain informed consent, assuring participants that the information acquired would be kept confidential, and to follow the guidelines outlined in the University of Roehampton code of ethics. Furthermore, participants were reassured that all questionnaires and consent forms were kept separately from each other to ensure anonymity.

### 5.4.3 Participants

Participants were 64 children who agreed to the video speech task (29 females and 35 males; aged from 8 to 11,  $M = 8.98$ ,  $SD = 0.79$ ). All participants for the current study were from Keystage two living in the south west area of London, UK. Participating schools responded to an email invitation to participate in an anxiety prevention research programme. Twenty Schools from the Richmond Borough were invited to participate in the research; however, only eight schools confirmed their participation.

With regard to the exclusion criteria, and for the purpose of the current study, children whose parents made us aware of any clinical diagnosis were excluded from the analyses. No children were known to have a clinical diagnosis of any kind, so the sample size was retained. In addition, only children aged 8 to 11 were included in the current study, based on existing research stating the age of onset for SAD to be between 7 to 13 years (e.g., Beidel & Turner, 2007; Costello et al., 2011; Knappe et al., 2011).

### 5.4.4 Measures

The *Emotion Regulation Index for Children and Adolescents* (ERICA; MacDermott, Gullone, Allen, King, Tonge, 2009), a validated measure for the assessment of key aspects of ER, particularly the processes, including “affective lability, intensity, valence, flexibility, and situational appropriateness” (Shields & Cicchetti, 1997, p. 910). It is based on Biesecker and Easterbrooks’ (2001) Emotion Regulation Checklist for Adolescents (ERCA), which was validated with a sample of adolescents aged around 16 years. Thus, some of the items of the ERCA were

revised in the ERICA to simplify the language appropriately for practice on children from 9 years of age. Thus, these questionnaires differ predominantly concerning item wording. The ERICA consists of 16 items that are scored on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The subscales measure emotional control, emotional self-awareness, and situational responsiveness, whereby the 1-5 ratings of all items are summed up to yield a total score with higher scores reflecting more adaptive or functional ER. In the present sample, the internal consistency of ERICA was high at  $\alpha=.82$ .

The *Social Phobia and Anxiety Inventory for Children* (SPAI-C; Beidel, Turner, & Morris, 1995) measures the level of SAD in children between 8-14 years of age. The questionnaire consists of 26 items that are scored on a 3-point Likert scale from 0 (never) to 2 (most of the time). A maximum score of 52 indicates “that the child experiences anxiety with a high frequency in a broad range of social settings” (Gauer, Picon, Vasconcellos, Turner & Beidel, 2005; p.796). The self-report measure is designed to assess symptoms of SA in children between 8–14 years. It has retained sound psychometric properties, including adequate test–retest reliability of 0.86 and 0.63 (after two-weeks and ten-months, respectively) as well as internal consistency of 0.95 (Beidel et al., 1995, 1998). According to the authors, the SPAI-C presents concurrent validity, which is demonstrated through the moderately significant correlations between social competence and reports of a child’s internalising behaviour. In the current study the SPAI-C was utilised as an initial screening measure as well as an index of change in social fears over the course of the task. The suggested clinical cut-off is 18 (Beidel et al., 1996) and provided the split



between high vs low SA in the present study. Cut-off scores were not differentiated by gender in the SPAI-C manual (Beidel et al., 1998). The SPAI-C had an excellent internal consistency in the present sample at  $\alpha=.97$ .

The *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 1997) is a brief behavioural screening form appropriate for 3-16 year olds and exists in numerous versions to meet the needs of educationalists, clinicians, and researchers. It is a measure designed for parents and teachers to report on the child's behaviour. All versions of the SDQ inquire about 25 positive and negative attributes, divided in the following scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and poor pro-social behaviour. All, but the pro-social behaviour subscale, are summed to generate a total difficulties score ranging from 0-40. The version for parents includes the same 25 items, slightly differently worded (Goodman, Meltzer, Bailey, 1998). Each subscale consists of five questions that can be answered on a 3-point response scale ("Not true", "Somewhat true", "Certainly true"), with a subscale score range of 0-10. For the purpose of this study these scales were not used for clinical diagnosis and instead for assessment purposes of behavioural difficulties, SA levels and their correlation to performance ratings purely. The internal consistency for the SDQ-P (parents' report) in the present study was high at  $\alpha=.83$ .

The *Speech Performance Rating Scale* (SPRS; Fydrich et al., 1998) was used in a slightly adapted version. Fydrich and colleagues developed the SPRS based on the available assessment measures by Trower and colleagues (1978). Positive ratings are assigned to standard levels of behaviour and negative ratings to imbalanced

behaviour (e.g., too much or too little). The authors developed extensive behavioural support for each scale point to enhance reliability. In addition, this support was tailored to provide finer distinctions between levels of social performance. The SPRS was designed for observations of video taped conversation between two people. As a result, it was adapted (permission was obtained by Dr Fydrich) to make it suitable for a 2 min speech task, rather than the role-play performance for which it was initially designed for. This presents a minor adaptation rather than a major redesign. The following items were included: (a) Gaze, whereby different eye-contact behaviour was evaluated; (b) Vocal Quality, which includes a variety of different components, such as volume, clarity, enthusiasm, and intrusiveness of speech; (c) Length, whereby monosyllabic responses, continuity, and the comprehension of responses were evaluated; (d) Discomfort ratings, which incorporated various levels of distress exposed during the speech; and (e) Conversation flow, which included the elements of appropriate self-disclosure, initiation of speech, and fluency in the speech. The items were rated on a descriptive scale from very poor (1) – very good (5) for Gaze, Vocal Quality, Length, and Conversation Flow, while Discomfort was rated on a descriptive scale from very high (1) – to very low (5). The sum of these ratings provides an internally consistent total score. The Cronbach's alpha of the SPRS in the current study was  $\alpha=.96$ , indicating a high level of internal consistency.

The *Performance Questionnaire* (PQ-C; Cartwright-Hatton et al., 2003), consists of two parts, which were used by the children to rate their own performance and how they felt during their speech. The first part is a visual analogue scale

ranging from 1 (very relaxed/very good) – 5 (very nervous/very bad), which measures how anxious the child felt before and after the task. The second part of the questionnaire consists of nine questions on their appearance during their speech, including a scale ranging from 1 (very much) – 4 (not very much); six questions on their feelings during the task on a scale from 0 (not at all) – 3 (very strong); and four questions each on their thoughts before and after their speech on a ‘yes – or no’ scale.

The *Objective Performance Questionnaire* (OPQ-C; Cartwright–Hatton et al., 2003), was used by the observer to rate the child’s performance during the 2-minute speech task. This scale includes only nine questions on how the child performed and appeared to the panel on a rating scale of 1 (very much) – 4 (not very much).

#### *5.4.5 Procedure*

Twenty schools of the Borough of Richmond were recruited via an email invitation explaining the purpose and procedures of the current study. In total, eight schools confirmed their participation in this programme. The project was initially discussed with the headteachers of the schools that expressed their interest in participation. This was conducted to clarify both the interests of the researcher and the school in terms of their pupils. On institutional approval, children and parents were invited to take part in this study through the participating school’s newsletter. Interested parents and children were provided with a letter of invitation outlining the aims and objectives of the project (Appendix II) followed by a consent form (Appendix IV) that reminded them of the nature of the research, their rights as participants, the

process of the research, and what would be required of them. Parents were further advised that the questionnaires in this study are designed simply to look at typical variation in aspects of ER and challenging situation, and not used as tools to diagnose a mental illness. Parents were then asked to sign and return the consent form.

A consent rate of 64 was obtained and children were asked to complete a set of questionnaires to begin with. These questionnaires also requested demographic information such as age and gender. Children completed the baseline self-report questionnaires (ERICA and SPAI-C) within normal class time. All students were asked to sit at their own desk and to listen carefully to the instructions that were provided. The main investigator of this study (MSc and BSc Psychology graduate) read the instructions of each questionnaire aloud to all children and assisted children who had difficulties understanding some of the words or questions throughout. Children were informed that all questionnaire responses were confidential and that there were no right or wrong answers. Parents were asked to complete one questionnaire (SDQ-P), within the same week to measure the levels of behavioural difficulties prior to the video task. In a following session, the children were asked to give a two- minute speech about themselves in front of a panel of two and a small group of children, while being video recorded. They were told that adults would later watch the video. The task was to be delivered in front of the investigator, in order to acquire the most accurate assessment of the gaze, vocal quality, length of speech, discomfort, and conversation flow felt during the speech (e.g., Cartwright-Hatton et

al., 2003; Emery, 2000). Children were advised that they could speak about any topic of interest, such as their friends, family, favourite pet, and/or activities.

With regard to assessing their levels of anxiety before and after the task, the children were asked to complete a visual analogue scale as part of the PQ-C before they began the speech, indicating on a scale of 1– 5 how ‘worried and scared’ they felt at that moment. The second part of the PQ-C assesses the children’s self-perception by including questions on how they thought they physically appeared, how they felt, what they thought throughout the task, and finally how they felt after the task. The speech task took place with the child standing in front of the group and the video camera. Children who were silent for more than 10 seconds were provided with a prompt from the researcher (e.g., ‘what do you like to do in your free time?’ or ‘do you have any pets?’). Upon completion of the video speech task, children were congratulated on their speech. They were then asked to complete the second part of the PQ-C while the panel was asked to rate the speech, body language and facial expression of each child during their performance. The panel during the speech task consisted of a Psychology graduate and the school’s SENCO. They were instructed to remain neutral and relatively passive, yet open to prompt where required throughout the two-minute speech task.

On completion children were thanked for their contribution and sent back to their classroom. Once the data were collected, a neutral panel consisting of an MPhil student in Psychology and a BSc student in Psychology (both BPS accredited graduates) analysed the video data at a later date based on the adapted SPRS at 4 different time points (T1= 0sec - 30sec, T2= 30sec - 60sec, T3= 60sec - 90sec, T4=

90sec – 120sec). The two collaborators watched the videos and rated each child on the adapted version of the SPRS. The observers rated the videos independently and did not have the opportunity to confer. Analysts were provided with a test-run before coding the tapes for this study. Their practice ratings were discussed and discrepancies were resolved. To ensure consistency throughout the study-coding period, raters met at the beginning of each coding session to review previously rated tapes. Members of the live panel and video analyses were blind to the child's actual SA and ER levels.

#### *5.4.6 Debriefing*

At the end of the study, participants were debriefed verbally and in writing. Each parent who contributed and allowed their child to participate, received a debrief form that discussed the nature of the study. It was reiterated that all information obtained during the study would remain confidential. If the participant had any further concerns regarding the study they were advised to contact the principle investigator, the schools' SENCO, the Director of Studies, and/or the Head of the Psychology Department (see Appendix VII).

#### *5.4.7 Data Analyses*

Firstly, descriptive statistics were obtained for the participants. Subsequently inter-rater reliability analyses using the Kappa statistic were performed to determine consistency among raters. For the purpose of assessing the relationship between SA, ER and participants' and observers' ratings Pearson's Correlation were conducted. Participants were divided into two categories (high vs. low) based on the existing cut off points for the administered questionnaires and the individuals' scores. To

evaluate the impact of high vs. low levels of SA and behavioural difficulties on various performance measures, several mixed 2x4 Analyses of Variance with SA and behavioural difficulties (high vs. low) as the between-subjects variable and time (T1, T2, T3, and T4) as the within-subjects variable were conducted on participants ratings of various measures (SPAI-C, and the SDQ-P) over time.

## **5.5 Results**

### **5.5.1 Preliminary analyses**

Prior to statistical analyses, the data were screened for the presence of outliers and violations of the assumptions of ANOVA. Very few outliers existed and considering the fact that they were legitimate cases and did not appear to be the result of coding mistakes, their deletion did not have a significant impact on the results. Thus, they were retained in the analyses and solely transformed to maintain the sample size. Table 5.1 presents the descriptive statistics for all psychometric questionnaires utilised prior to the performance task and each performance component over two minutes. Participants were divided into two categories (high vs. low) based on the author's recommendations on cut-off points and the participants' scores in the questionnaires. The questionnaires measured SA, behavioural difficulties (as per parents' report), and ER. All variables demonstrated high reliability ranging from 0.82 to 0.97 as measured by Cronbach's Alpha. In particular, ERICA  $\alpha = 0.82$ , SDQ-P  $\alpha = 0.83$ , and SPAI-C  $\alpha = 0.97$ , which all indicate a high level of internal consistency for each scale.

The results of the interrater analysis for the behavioural measures are as follows:

For Gaze it is Kappa = 0.37 with  $p < 0.001$ ; for Vocal Quality it is Kappa = 0.39 with  $p < 0.001$ ; for Length of Speech it is Kappa = 0.33 with  $p < 0.001$ ; for Discomfort it is Kappa = 0.38 with  $p < 0.005$ ; and for Conversation Flow it is Kappa = 0.29 with  $p < 0.005$ . While statistically significant, there was fair agreement between the two video analysts. However, the inter-rater reliability of the total mean performance ratings for both video analysts was found to be Kappa = 0.41 ( $p < .001$ ), which resembles a moderate agreement.

*Table 5.1:*

Mean Scores and Standard Deviations of Behavioural Measures by SPAI-C, and SDQ-P Measures

Behavioural Measures	SPAI-C				SDQ-P			
	(total score)				(total score)			
	Low $n = 35$		High $n = 28$		Low $n = 46$		High $n = 12$	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)
<b>Gaze (T1)</b>	2.97	(0.88)	2.84	(1.03)	2.92	(0.98)	3.04	(0.75)
<b>Gaze (T2)</b>	2.77	(0.87)	2.70	(0.99)	2.71	(0.90)	2.92	(1.00)
<b>Gaze (T3)</b>	2.91	(0.77)	2.70	(0.84)	2.77	(0.76)	3.00	(0.91)
<b>Gaze (T4)</b>	2.97	(0.78)	2.75	(0.89)	2.89	(0.77)	2.75	(0.94)
<b>Vocal Quality (T1)</b>	3.10	(1.03)	2.61	(1.21)	2.87	(1.14)	3.33	(0.99)
<b>Vocal Quality (T2)</b>	2.90	(0.94)	2.34	(1.14)	2.61	(1.06)	3.13	(1.00)
<b>Vocal Quality (T3)</b>	3.00	(0.99)	2.36	(1.00)	2.64	(1.05)	3.17	(0.99)
<b>Vocal Quality (T4)</b>	3.13	(0.90)	2.34	(0.91)	2.78	(1.02)	3.08	(0.88)



**Table 5.1 continued**

Behavioural Measures	SPAI-C				SDQ-P			
	(total score)				(total score)			
	Low <i>n</i> = 35		High <i>n</i> = 28		Low <i>n</i> = 46		High <i>n</i> = 12	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)
<b>Length of Speech (T1)</b>	3.31	(1.04)	3.27	(0.99)	3.30	(1.04)	3.46	(0.94)
<b>Length of Speech (T2)</b>	3.11	(0.99)	2.73	(1.10)	2.96	(1.09)	3.17	(0.96)
<b>Length of Speech (T3)</b>	3.07	(0.99)	2.77	(0.96)	2.85	(1.01)	3.33	(0.96)
<b>Length of Speech (T4)</b>	3.01	(0.82)	2.55	(1.06)	2.80	(1)	2.96	(0.87)
<b>Discomfort (T1)</b>	2.76	(0.78)	2.84	(0.98)	2.89	(0.91)	2.54	(0.81)
<b>Discomfort (T2)</b>	2.76	(0.90)	2.73	(1.00)	2.85	(0.94)	2.75	(0.92)
<b>Discomfort (T3)</b>	2.93	(0.74)	2.77	(0.89)	2.92	(0.82)	2.88	(0.80)
<b>Discomfort (T4)</b>	2.87	(0.86)	2.70	(0.96)	2.84	(0.87)	2.75	(1.16)
<b>Conversation Flow (T1)</b>	3.20	(0.93)	3.27	(0.92)	3.22	(0.96)	3.50	(0.56)
<b>Conversation Flow (T2)</b>	3.04	(0.89)	2.75	(1.01)	2.92	(0.99)	3.13	(0.91)
<b>Conversation Flow (T3)</b>	3.06	(0.94)	2.70	(0.75)	2.86	(0.91)	3.04	(0.89)
<b>Conversation Flow (T4)</b>	3.14	(0.80)	2.54	(0.93)	2.84	(0.92)	3.04	(0.94)

*Note:* SPAI-C= Social Phobia and Anxiety Inventory for Children; SDQ-P= Strengths and Difficulty Questionnaires for Parents. Lower means scores for discomfort resemble higher discomfort (due to the opposing scale, very high (1) to very low (5) compared to the other scales.

### 5.5.2 Hypothesis 1: The Relationship between SA, ER and PQ-C, OPQ-C

Table 5.2:

Correlations between SA, ER and Children's Self- Ratings and Observer- Ratings

Variables	ERICA (Emotion Regulation)	SPAI-C (Social Anxiety)	PQ-C (Children's Self-Ratings)	OPQ-C (Panel Ratings)
<b>ERICA (Emotion Regulation)</b>				
<b>SPAI-C (Social Anxiety)</b>	-.12			
<b>PQ-C (Children's Self-Ratings)</b>	-.32**	.22*		
<b>OPQ-C (Panel Ratings)</b>	-.36**	.20	.37**	

Note: One-tailed \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ . ERICA= Emotion Regulation Index for Children and Adolescents; SPAI-C= Social Phobia and Anxiety Inventory for Children; PQ-C= Performance Questionnaire; OPQ-C= Objective Performance Questionnaire (on both performance questionnaires higher scores resembled negative ratings).

As table 5.2 presents, there was a strong, negative correlation between ERICA and PQ-C (children's self-ratings) indicating, as expected, that participants with poorer levels of ER reported higher scores on the PQ-C, which resembled a negative rating of themselves. In addition, the positive correlation between SPAI-C and PQ-C demonstrated, as expected, that participants with higher levels of SA reported higher scores on the PQ-C, again indicating a more negative self-rating.

With regard to the panel ratings a moderate, negative correlation was found between ERICA and OPQ-C, indicating, as expected, that participants with poorer ER levels were rated higher on the OPQ-C, which coincided with a negative rating of the participant by the panel. Lastly, the significant positive correlation between children's self-ratings (PQ-C) and panel ratings (OPQ-C) indicated higher self-ratings to be associated with higher panel ratings, both resembling more negative ratings.

### *5.5.3 Hypothesis 2: The Difference between Self- and Observer-Ratings in High SA and Low ER*

No significant difference was found between self- (PQ-C) and observer- ratings (OPQ-C) in high SA and low ER ( $F < 1$  and  $p > .1$ ).

### *5.5.4 Hypothesis 3: ANOVA's of the Video Analysis*

64 children (29 females and 35 males; aged from 8 to 11,  $M = 8.98$ ,  $SD = 0.79$ ) participated in the video speech task.

Several Mixed  $2 \times 4$  Analyses of Variance with SA and behavioural difficulties (high vs. low; SA through the SPAI-C and behavioural difficulties through the SDQ-P) as the between-subjects variable and time (T1, T2, T3 and T4) as the within-subjects variable were conducted on participants' performance over two minutes (divided in four segments).

#### *Performance measures by SPAI-C*

With regard to Vocal Quality, there was a significant main effect of time,  $F(3,183) = 2.63$ ,  $p = .05$ ,  $\eta^2 = .04$ , and social anxiety group as measured by SPAI-C,  $F(1,61) = 7.06$ ,  $p = .01$ ,  $\eta^2 = .10$ . Inspection of the means indicated that Vocal Quality scores differed across time (T1:  $M = 2.88$ ,  $SD = 1.03$ , T2:  $M = 2.65$ ,  $SD = 1.06$ , T3:  $M = 2.71$ ,  $SD = 1.04$ , T4:  $M = 2.78$ ,  $SD = 0.98$ ) and highly socially anxious children generally scored lower on vocal quality than children with lower levels of social anxiety (Low SA:  $M = 3.03$ ,  $SD = 0.97$ ; High SA:  $M = 2.41$ ,  $SD = 1.07$ ). This is further illustrated in Figure 5.1. There was no significant group by time interaction found,  $F(3,183) = 1.08$ ,  $p > .1$ .

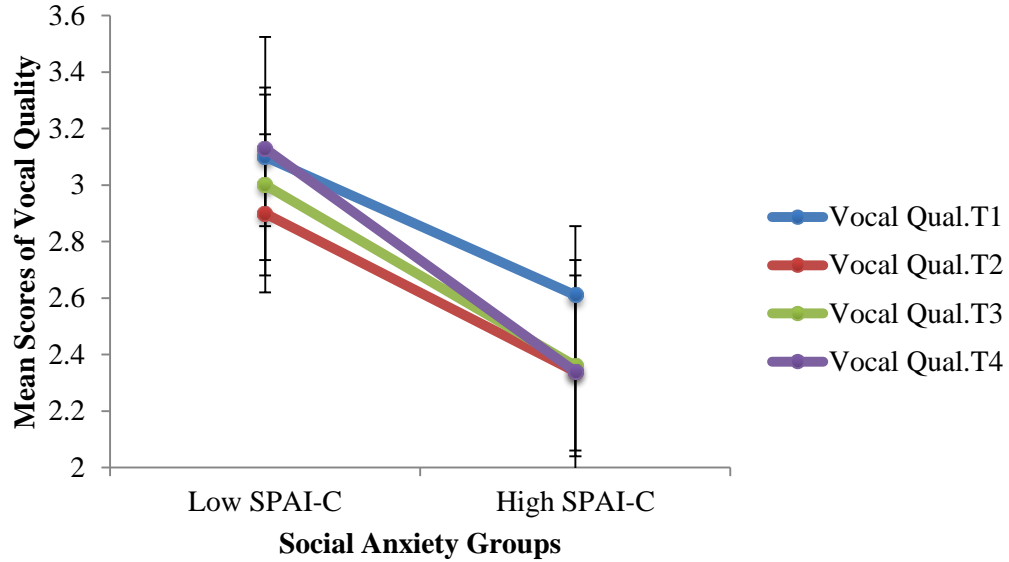


Figure 5.1: SPAI-C on Vocal-Quality Scores. Error bars represent standard error.

The pairwise comparisons for the significant main effect of time, corrected using Bonferroni adjustments (adjusted alpha level of 0.01 per test), indicated a significant difference between time 1 and time 2, (T1:  $M = 2.83$  to T2:  $M = 2.65$ ,  $p < .01$ ) and non-significant differences across other times ( $p > .01$ ).

With regard to Length of Speech, there was a significant main effect of time  $F(3,183) = 9.84$ ,  $p < .001$ ,  $\eta^2 = .14$ , but no significant main effect of social anxiety group as measured by SPAI-C,  $F(1,61) = 1.82$ ,  $p > .1$ , and no significant group by time interaction,  $F(3,183) = 1.68$ ,  $p > .1$ . Inspection of the means indicated that Length of Speech scores differed across time (T1:  $M = 3.29$ ,  $SD = 1.01$ , T2:  $M = 2.94$ ,  $SD = 1.05$ , T3:  $M = 2.94$ ,  $SD = 0.98$ , T4:  $M = 2.81$ ,  $SD = 0.95$ ). Figure 5.2, illustrates this further.

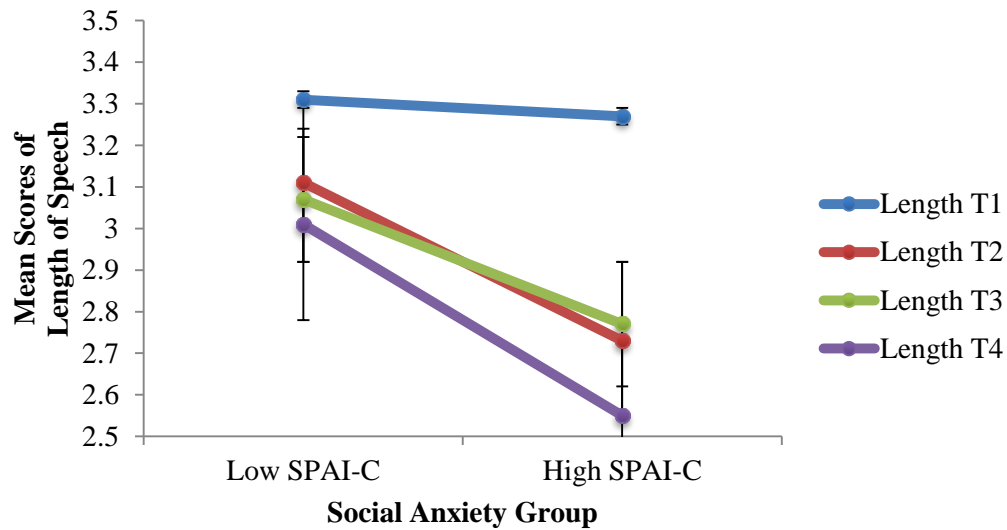


Figure 5.2: SPAI-C on Length of Speech Scores. Error bars represent standard error.

The pairwise comparisons for the significant main effect of time, corrected using Bonferroni adjustments (adjusted alpha level of 0.01 per test), indicate a significant difference between time 1 and time 2 (T1:  $M = 3.29$  to T2:  $M = 2.94$ ,  $p < .01$ ), time 1 and time 3 (T1:  $M = 3.29$  to T3:  $M = 2.94$ ,  $p < .01$ ), as well as time 1 and time 4 (T1:  $M = 3.29$  to T4:  $M = 2.81$ ,  $p < .001$ ) and non-significant differences across other times ( $p > .01$ ), suggesting that length of speech reduced after the first time interval.

With regard to Conversation Flow, there was a significant main effect of time,  $F(3,183) = 7.78$ ,  $p = <.001$ ,  $\eta^2 = .11$  and a significant Time x SPAI-C interaction,  $F(3,183) = 4.52$ ,  $p = .004$ ,  $\eta^2 = .07$ , but no significant main effect for social anxiety group as measured by SPAI-C,  $F(1,61) = 2.27$ ,  $p > .1$ . Inspection of the means indicated that Conversation flow scores differed across time (T1:  $M = 3.23$ ,  $SD = 0.92$ , T2:  $M = 2.91$ ,  $SD = 0.95$ , T3:  $M = 2.90$ ,  $SD = 0.87$ , T4:  $M = 2.87$ ,  $SD = 0.91$ ). The significant Time x SPAI-C interaction indicates a significant difference between levels of SA (as measured by SPAI-C) over time in conversation flow, with higher socially anxious children indicating a greater decrease in

conversation flow over time (Low SA T1:  $M = 3.20$ ,  $SD = 0.93$ ; T2:  $M = 3.04$ ,  $SD = 0.89$ , T3:  $M = 3.06$ ,  $SD = 0.94$ , T4:  $M = 3.14$ ,  $SD = 0.80$ ; High SA T1:  $M = 3.27$ ,  $SD = 0.92$ ; T2:  $M = 2.75$ ,  $SD = 1.01$ , T3:  $M = 2.70$ ,  $SD = 0.75$ , T4:  $M = 2.54$ ,  $SD = 0.93$ ). This is further presented in Figure 5.3 where the graph represents a decrease in conversation flow in children high in SA (as measured by SPAI-C) compared to children low in SA. This suggests a better conversation flow in children low in SA as opposed to children with higher levels of SA over time.

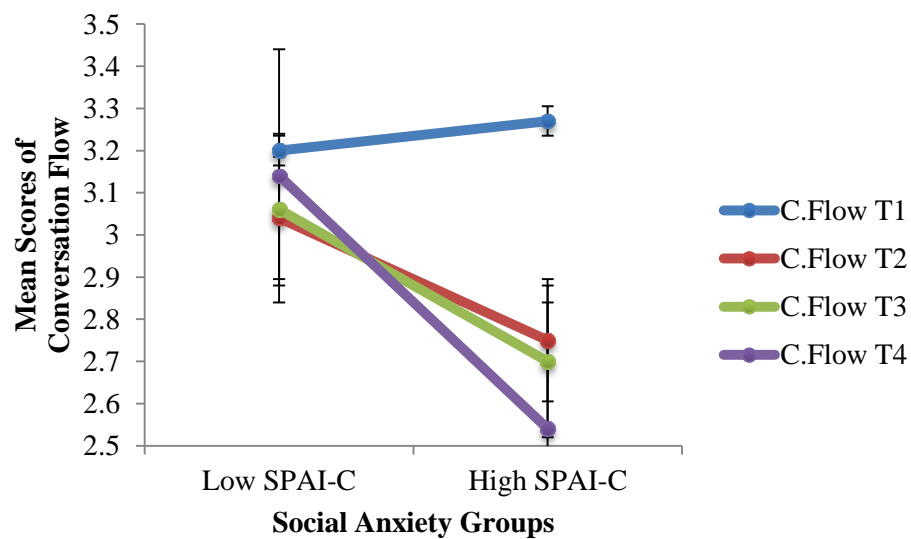


Figure 5.3: SPAI-C on Conversation Flow Scores. Error bars represent standard error.

Using BC (adjusted alpha level of 0.01 per test) post hoc comparisons were carried out to detect any differences in mean time scores between high vs. low SA on Conversation Flow.

Independent samples t-test revealed a significant difference between high and low SA group at T4;  $t(61) = 2.78$ ,  $p < .01$  (High:  $M = 2.54$ ,  $SD = 0.93$ ; Low:  $M = 3.14$ ,  $SD = 0.8$ ), with the low SA group showing higher levels of conversation flow compared to the higher SA group at T4.

The pairwise comparisons for the significant main effect of time, corrected using Bonferroni adjustments, indicated a significant difference between time 1 and time 2 (T1:  $M = 3.23$ ,  $SD = 0.92$ , T2:  $M = 2.91$ ,  $SD = 0.95$ ,  $p < .01$ ), time 1 and time 3 (T1:  $M = 3.23$ ,  $SD = 0.92$ , T3:  $M = 2.90$ ,  $SD = 0.87$ ,  $p < .01$ ) as well as time 1 and time 4 (T1:  $M = 3.23$ ,  $SD = 0.92$ , T4:  $M = 2.87$ ,  $SD = 0.91$ ,  $p < .01$ ) and non-significant differences across other times ( $p > .01$ ), showing a decrease in conversation flow after the first interval.

#### *Performance measures by SDQ-P*

With regard to Length of Speech, there was a significant main effect of time  $F(3,168) = 5.61$ ,  $p = .001$ ,  $\eta^2 = .091$ , but a non-significant main effect of behavioural difficulty group as measured by SDQ-P,  $F(1,56) = 0.73$ ,  $p > .1$ , and a non-significant group by time interaction,  $F(3,168) = 0.82$ ,  $p > .1$ . Inspection of the means indicated that Length of Speech scores differed across time (T1:  $M = 3.34$ ,  $SD = 1.02$ , T2:  $M = 3.00$ ,  $SD = 1.06$ , T3:  $M = 2.95$ ,  $SD = 1.01$ , T4:  $M = 2.84$ ,  $SD = 0.97$ ). This is further illustrated in Figure 5.4.

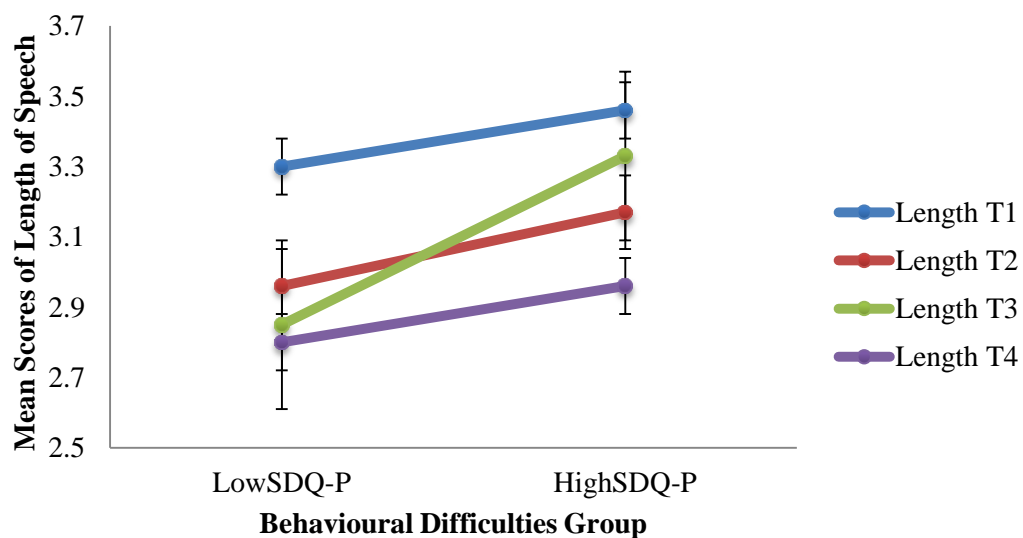


Figure 5.4: SDQ-P on Length of Speech Scores. Error bars represent standard error.

The pairwise comparisons for the significant main effect of time, corrected using Bonferroni adjustments (adjusted alpha level of 0.01 per test), indicated a significant difference between time 1 and time 4 (T1:  $M = 3.34$  to T4:  $M = 2.84$ ,  $p < .01$ ), and non-significant differences across other times ( $p > .01$ ), suggesting a drop in the length of speech by time 4 after the first time interval.

With regard to Conversation Flow, there was a significant main effect of time  $F(3,168) = 5.66$ ,  $p = .001$ ,  $\eta^2 = .09$ , but no significant main effect of behavioural difficulty group as measured by SDQ-P,  $F(1,56) = 0.66$ ,  $p > .1$ , and no significant group by time interaction,  $F(3,168) = 0.71$ ,  $p > .1$ . Inspection of the means indicated that Conversation Flow scores differed across time (T1:  $M = 3.28$ ,  $SD = 0.90$ , T2:  $M = 2.97$ ,  $SD = 0.97$ , T3:  $M = 2.90$ ,  $SD = 0.90$ , T4:  $M = 2.88$ ,  $SD = 0.92$ ). Figure 5.5 depicts both groups of children to decrease in conversation flow over time.

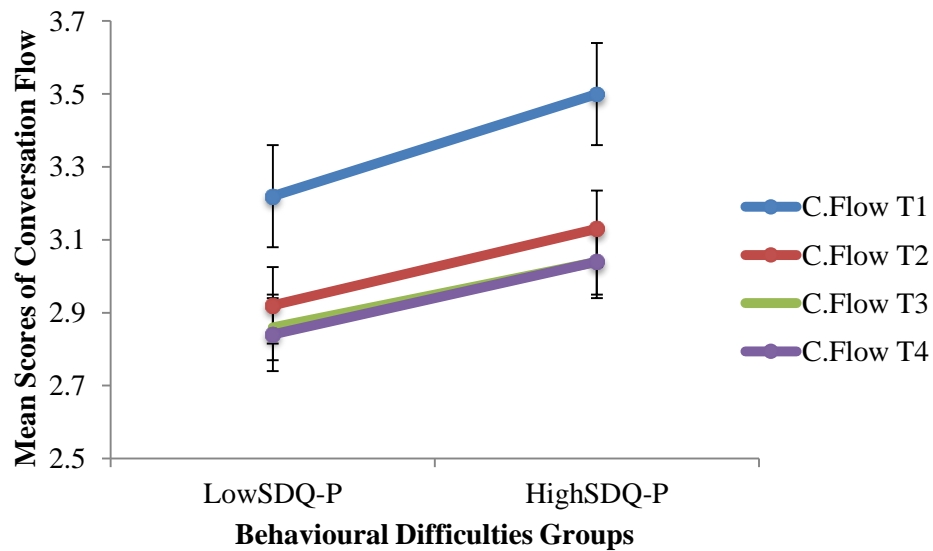


Figure 5.5: SDQ-P on Conversation Flow Scores. Error bars represent standard error.

The pairwise comparisons for the significant main effect of time, corrected using Bonferroni adjustments (adjusted alpha level of 0.01 per test), indicate a significant difference between time 1 and time 3 (T1:  $M = 3.28$  to T3:  $M = 2.90$ ,  $p < .01$ ), (and



only a marginally significant difference at time 1 and time 2 (T1:  $M = 3.28$  to T2:  $M = 2.97$ ,  $p = .02$ ), and time 1 and time 4 (T1:  $M = 3.28$  to T4:  $M = 2.88$ ,  $p = 0.3$ ), and non-significant differences across other times ( $p > .01$ ), suggesting that the conversation flow reduced after the first time interval.

There were no significant main effects or interactions between Gaze and the SA and behavioural difficulties measures ( $F < 1$  and  $p > .1$ ).

#### *5.5.5 Summary of Key Findings*

The hypotheses were supported or rejected as follows:

- (1) There was a significant positive correlation between SA and PQ-C (children's self-rating) and a significant negative correlation between ER and PQ-C, and ER and OPQ-C (observer ratings), supporting the first hypothesis.
- (2) There was no significant difference between the self-ratings (PQ-C) of children with higher levels of SA and lower levels of ER and the observer ratings (OPQ-C), rejecting the second hypothesis.
- (3) There was a significant difference in the performance measures vocal quality and conversation flow over time (2 minute performance) between different levels of SA, overall supporting the third hypothesis.

## *5.6 Discussion*

The main goal of Study One was to investigate the relationship between SA and ER and self- and observer-ratings. Furthermore, the aim was to explore the difference between self- and observer-ratings. Lastly, this study intended to determine the behavioural inhibitions of a community sample of children with high vs. low SA, and behavioural difficulties on various performance measures. The results showed that elevated levels of SA have negative impacts on the performance measures of vocal quality and conversation flow. We did not find a significantly negative effect of SA respectively in regard to gaze, discomfort, length of speech, and no significantly negative effect of behavioural difficulties on any performance measures, though there seemed to be a general decrease on the majority of performance measures after the first interval. Furthermore, the results indicate that children with higher levels of ER rate themselves better than children with lower levels of ER, while those with higher levels of SA rated themselves worse in contrast to their counterparts.

### *5.6.1 Primary Findings*

In support of the first hypothesis, Pearson's correlation analyses revealed significant results. Thus, lower ER levels were associated with poorer self- and panel ratings. In addition, higher levels of SA were related to poorer self-ratings. These findings are in agreement with past studies, where individuals diagnosed with SAD provided worse self-ratings on their speech performance and displayed actual performance deficits in conversation (e.g., Cartwright-Hatton et al., 2005; Voncken, Bögels, 2008) or speech tasks (e.g., Cartwright-Hatton et al., 2003). Based on the ratings of the video analysts, particularly, SA and ER (as reported by the child) were associated with lower social performance ratings as perceived by the child. Hence, and in

accordance with Clark and Wells (1995), social performance is compromised if self-focused attention is high, which most likely is the case in socially anxious individuals. Surprisingly, however, no significant difference was found between self- and observer-ratings, rejecting the second hypothesis. This is in contrast to existing findings (e.g., Beck & Dozios, 2011; Mallott, 2009; Stopa & Clark, 1993; Voncken & Bögels, 2008) and may be due to the different nature of the sample (non-clinical vs. clinical) as well as the task.

Moreover, the third hypothesis regarding a significant difference in various performance measures (gaze, vocal quality, length of speech, conversation flow, and discomfort) over time (two minute performance) between different levels of SA was overall supported, with the exception of non-significant effects of SA and gaze, discomfort, and length of speech, as well as non-significant effects of behavioural difficulties on any performance measures. The Mixed 2 (high vs. low) x 4 (T1, T2, T3, and T4) ANOVA revealed significant main effects of time on all performance measures but gaze and discomfort, a significant main effect of SA group with regard to vocal quality, and a significant interaction between conversation flow and SA (as measured by SPAI-C). Post-hoc comparisons revealed children with elevated levels of SA to present significantly lower scores on the vocal quality and conversation flow by the end of the task (T4), indicating reduced enthusiasm and quieter, less clear vocals, and a more disrupted conversation flow over time. This indicates the negative effect elevated levels of SA have on these particular performance measures.

In the light of the above, the results of the current study contribute to the literature with regard to the consequences of heightened SA on performance. Taken together, the results showed that elevated levels of SA have a negative impact on performance measures, such as, vocal quality and conversation flow, but not on

discomfort, gaze, or length of speech. The significant main effects of time suggest a general decrease in vocal quality, length of speech, and conversation flow in children. Additionally, there are significant relationships between SA, ER and self- and panel-perception. The negative impact of high (non-clinical) SA and low ER, as well as the general decrease in performance over time could contribute to the maintenance of SA and the development of SAD (e.g., Clark, 2001; Bögels & Mansell, 2004; McLaughlin, & Hatzenbuehler, 2011). Thus, the inclusion of CBT and ER components in prevention or intervention programmes could reduce this risk. This is in line with previous findings suggesting that the increase of ER and decrease of SAD could have a significant impact on the bias beliefs of individuals diagnosed with SAD (Mahone et al., 1993). Cognitive models of SAD implicate that maladaptive beliefs and assumptions play a significant role in the maintenance and possibly the aetiology of SAD (Kim & Ja Oh, 2010; Stopa & Clark 1993; Weeks et al., 2005). This is in line with the significant correlations of the current study. The belief that one is being examined by others and being held to unachievable performance standards has a crucial impact on thoughts, emotions, and behaviour in social-evaluative situations. Research has shown that CBT has a positive impact on these perceptions, by reducing them drastically (Hofmann, 2000; Wilson & Rapee, 2005). However, more studies are required to reveal other factors that have a bearing on the beliefs that may also be operating in SAD. For example, research suggests that the belief that others are more socially capable and that one will behave in an unskilled manner in social situations also contributes to SAD independently of the fear of negative evaluation. These beliefs distinguish people with SAD from individuals without SAD (Fergus et al., 2009; Turner et al., 2003).

Nevertheless, and in line with previous literature, the negative consequences of SAD in children further underline the importance of ER (e.g., Clark & Wells, 1995; Kashdan, 2007; Moscovitch & Hofmann, 2007; Werner & Gross, 2010). As the literature review and introductory chapter outlined, individuals diagnosed with SAD seem to present negative consequences on various factors of their behaviour and cognitive functioning, which, in turn, contribute to the maintenance of this disorder (e.g., Bögels & Mansell, 2004; McLaughlin, & Hatzenbuehler, 2011; Rapee & Heimberg 1997).

The current study is a step towards contributing new findings in terms of the negative consequences elevated levels of (non-clinical) SA have on an individual's performance, particularly with regard to conversation flow. Furthermore, it provides a new insight into the significant relationship between low levels of ER, high levels of SA and self- and observer ratings. Considering the consistency of the current findings with previous literature as well as the inconsistency with other existing findings, it is crucial to refine these conclusions. The majority of the available research has focused on conversation or interview tasks, predominantly on adults, clinical, and/or rather small sample sizes, and limited behavioural measures. Moreover, the social behaviour measures were usually restricted to four or less, and the studies generally included merely one questionnaire on SAD. Thus, the current study aimed to address some of the key limitations that exist within the current literature. Critically, the present study included a community sample of children, SA, behavioural difficulties, and ER measures, a variety of social behaviour measures (five in total), a video panel, as well as self- and observer ratings.

### *5.6.2 Unexpected Findings*

In contrast to previous findings, the current study did not find a significant difference between the self-ratings of children with higher levels of SA and lower levels of ER and the observer ratings. This unexpected finding (considering previous literature suggested more self-biased perception in participants in contrast to observer ratings) may be due to the community sample utilised in the current study and the nature of the task. The study by Voncken and Bögels (2008), for example, found that individuals diagnosed with SAD not only underestimate their social performance during a conversation to a higher degree than during a speech, but also demonstrated actual performance problems throughout a conversation rather than during their speech. This might be based on individuals diagnosed with SAD to possibly associate anxious appearance with social behaviour problems. In contrast, Stopa and Clark (1993) found SAD patients to underestimate their social performance during a conversation, which may be due to their less complex nature of their task (e.g., number of confederates to interact with).

With regard, to performance deficits the current findings demonstrated significant main effects of time on a variety of speech measures and a significant interaction between time and SA concerning conversation flow. This is, partly, in contrast to the findings by Rapee and Lim (1992) who demonstrated no performance difference during a speech in patients with SAD. However, the post hoc comparisons of the current study revealed a significant difference between time 1 and time 2, time 1 and time 3 and time and time 4, though no significant difference between high vs. low SA (as measured by SPAI-C) on Length of Speech. In addition, no significant differences were found in high vs. low behavioural difficulties on Length of Speech and Conversation Flow across time. This may have been due to general difficulties

in getting children to talk for a certain amount of time regardless of their behavioural difficulties and anxiety levels. Moreover, behavioural difficulties may simply not be as disruptive to children's performance as elevated levels of SA. Furthermore, and in accordance with Strahan (1998), the task may not have been sufficiently challenging to cause significant differences in performance on all measures. It is however, noteworthy that the children in the high SDQ-P group were only 12 in contrast to 46 children in the high SDQ-P group, which may also explain these results.

The current findings, regarding vocal quality and conversation flow are, however, in line with findings by Hofmann and colleagues (1997) who reported that individuals diagnosed with SAD pause more during a speech when compared to control participants. The non-significant findings regarding discomfort may suggest that non-clinical SA does not impact levels of discomfort. A different sample size and nature may have revealed other findings. In addition, participants may have felt higher levels of discomfort prior to and on completion of the speech task, yet the attentional demands of the task may have distracted them from their discomfort during the task.

Lastly, the current findings did not uncover a significant difference between gaze behaviour in participants with high versus low SA, which is in contrast with some earlier results (e.g., Horley et al., 2004; Mallot et al., 2009; Schneier et al., 2011), yet in agreement with findings by others (e.g., Beidel et al., 1985; Hofmann et al., 2002). This may be the result of different methodological approaches and the nature of the employed sample. The fact that the current study employed a community sample may suggest that gaze, for example, is mainly affected by clinical SAD. The current study is not necessarily comparable to clinical studies as it suggests that certain variables seem to be affected by clinical SAD only, whilst

others are inhibited through purely heightened levels of SA. This in turn underlines the importance of including methods that can enhance outcomes in prevention programmes.

### *5.6.3 Limitations*

This study was not without its limitations. Firstly, the PQ-C and OPQ-C, in common with most research in this area, has limited data pertaining to their reliability and validity. This is despite being designed for the purposes of studies such as the current one. However, the validity of these assessment measures derives support from the findings of this and other studies (e.g., Essau et al., 2014). Secondly, the sample was restricted to non-clinically referred children attending a primary school in the south west area of London. Accordingly, the findings may not be generally applicable to other areas in the UK and may not reflect the processes operating in clinical SAD. However children who scored high in SA on the SPAI-C and the subscale of the SCAS were above the suggested clinical cut-off of 18 (Beidel et al., 1996) and although no diagnosis can be made solely on the basis of this questionnaire, many of the participants in this study had relatively high levels of SA symptoms. In addition, this presents the consequences of heightened SA levels. Thirdly, the ER questionnaires are limited to the level of understanding and recollection of the most current experience linked with the most recent emotion experienced (Fredrickson, 2000; Stone et al., 1998) in children and, therefore, could have an impact on the reports of trait ER. Despite some of these limitations, there are also strengths to the current study that ought to be considered.

### *5.6.4 Strengths*

The overall outcomes of the present study could be of high relevance in the prevention of SAD. The findings contribute to the existing literature in this area,



particularly due to the inclusion of a variety of behavioural and observational measures. This is the main strength of the current study as it addressed a number of present concerns and limitations and revealed supporting results that could inform prevention programmes for SA(D). A diverse, community sample of children was included, incorporating a significant age group. The present study was concerned with the cognitive and social developments children go through in these ages, and how they perform an exposure task in their natural setting. Furthermore, the various behaviour measures used, including observational analysis, the inclusion of self-and observer-ratings, as well as the assessment of ER levels differentiate the current study from existing ones in an advantageous way. The current results support the notion of some performance impairments and biased self-perception in children with elevated levels of SA and low levels of ER. This, in turn, could enhance the technical refinements of necessary CBT- and ER-based components that could support the reduction and development of SAD. These findings were obtained through empirical as well as objective measures, which in the concept of active practice is a direct goal of research. Considering the negative consequences and inhibitions that elevated levels of SA and low ER appeared to have on children's performance and ratings, this indicates that these could be contributing factors in the maintenance of SA, which could translate into clinical SAD at a later stage. Thus, the importance of the current findings from a theoretical and practical perspective is underlined. As such the findings are relevant to current research concerning the raising numbers of young individuals diagnosed with SAD (Beidel et al., 2000; Hitchcock et al., 2009; Rapee & Spence, 2004) and the necessity to include social and ER enhancement skills (Gross, Richards, John, 2006; Gross & Munoz, 1995).

#### *5.6.5 Interpretation of Findings and Future Directions*

The results of the current study indicate a number of relevant CBT- and ER-based components, such as exposure, cognitive restructuring, reappraisal, and positive self-talk, and the importance of combining these in the prevention and intervention of SAD in children. This was mainly based on the performance impairments observed across time on vocal quality, length of speech, and conversation flow and on the performance impairments found in high compared to low SA in children on two different performance measures. In addition, the significant correlations between SA and ER and self- and observer-ratings underlined the importance of specific components further. Considering the non-clinical sample of the current study, the information acquired highlights that there is a need to reconsider some technicalities of treatment and prevention components for children with SA(D). According to the existing literature some of the reported impairments derive from poor social skills (e.g., Miers et al., 2010; Schneider, 2009), while others argue that the cognitive impairments and self-perception play a crucial role (e.g., Kanai et al., 2009; Tuschen-Caffier et al., 2011). Thus, programmes aiming to reduce levels of SA and ER should consider the enhancement of social, as well as emotion regulation skills that also enhance cognitive deficiencies and biased self-perception.

It is clear from the current findings that both cognitive and behavioural elements should be addressed in individuals diagnosed with SAD, focusing on the negative appraisals of their performance and challenging their unhelpful emotions and thoughts. This should be done in a child-friendly and entertaining way to encourage this learning process. Public-speaking performance by anxious children can be disturbed by the distraction of attention to other cognitive processes. They might pay more consideration to the way they think they may be perceived, and how

they feel during a speech (Carver & Scheier, 1978; Daly et al., 1989). The findings of the current study revealed impairments, particularly, in the vocal quality and the conversation flow of performing children, that stress the cognitive, behavioural, and emotional challenges experienced by children high compared to low in SA. The significant main effects of time on some performance measures as well as the significant correlations between SA, ER, and self- and panel-ratings further indicate the importance of including CBT as well as ER components in programmes that are aimed at reducing levels of SA and increasing levels of ER to prevent the development of SAD.

Generally, children with higher levels of SA appeared to be less skilled in applying ER strategies, which was observable in their impaired video performance. These discoveries are in contrast to earlier findings that showed no inferior performance in socially anxious individuals (e.g., Beidel et al., 1985; Rapee & Lim, 1992; Strahan, 1998). This inconsistency may be due to methodological differences and dissimilarities in samples. For example, the interview task in Strahan's study may not have been sufficiently challenging to cause significant differences in performance. In addition, participants may have felt anxious prior to and on completion of the speech task, yet the attentional demands of the task may have effectively 'shut down' or displaced their SA for the duration of the task. Furthermore, the results showed no significant differences recorded in gaze behaviour between children with low compared to high SA. This is in line with some previous studies (e.g., Hofmann et al., 1997), though inconsistent with findings from others (Jurich & Jurich, 1974; Wiens, Harper, & Matarazzo, 1980). However, in the latter studies, authors looked at children with anxiety and thus, gaze might have been a relevant indicator of anxiety but not in non-clinical or sub-clinical samples. Hence,

the current results are in line with studies suggesting that eye contact alone does not discriminate (socially) anxious and non-anxious participants (Beidel et al., 1985; Glasgow & Arkowitz, 1975).

Moreover, the current findings support the notion that elevated levels of SA have negative impacts on particular behavioural measures as well as on self-and observer ratings. According to Rapee (1995), SAD is related to poor social performance rather than discrete or specific skills deficits. For example, group differences could reflect general anxiety rather than a lack of skills per se. Furthermore, the notion of safety behaviours (Clark & Wells, 1995; Wells et al., 1995) may possibly serve to impair performance due to the way in which these behaviours can be misread as unusual, awkward, distant or unfriendly (Clark & Wells, 1995). Consequently, from a treatment perspective, it is necessary to establish the nature of 'negative' behaviours displayed. If such behaviour suggests generally poor social performance, then skills training in this area may be suitable, whereas if such behaviours increase in relation to anxiety, relaxation training may be more suitable. As a result, the findings could help preventative programmes to focus on the combination of social and emotional skills training based on CBT in order to reduce the maladaptive consequences of elevated non-clinical SA and to prevent its clinical development.

In summary, the current findings emphasise the value of multiple assessments in multiple modalities (cf. McNeil, Ries, & Turk, 1995). Furthermore, it stresses the importance of considering heterogeneity in both anxious and non-anxious samples (Hofmann & Roth, 1996). Finally, the results underline the importance of considering self-perception enhancement skills, the focus on positive thoughts and feelings as well as challenging unhelpful thoughts and emotions in

training programmes for SA(D) in children.

#### *5.6.6 Conclusion and Research Implications*

Overall, the results demonstrated the consequences of elevated levels of SA on some performance measures, particularly on the vocal quality and the conversation flow, in a non-clinical child population. The findings further highlighted the significant relationship between SA, ER and self- and observer-ratings. As a result, this study underlines the importance of CBT and ER components in programmes that are aimed at reducing levels of SA and increasing levels of ER. This, in turn, could minimise the negative consequences on performance that elevated levels of SA may have in supporting the maintenance of these levels and possibly the development of SAD. The broad implications of these findings are, therefore, promising. However, future research should consider other relevant components such as larger sample sizes to include developmental aspects from the perspective of age. Furthermore, the mediating aspects of safety behaviours in different, more natural speech tasks could enhance these findings and increase their generalizability. Nevertheless, the subjective assessment followed by observational behavioural assessment of SA as well as ER is rather scarce and the current research, therefore, contributes to the existing literature. The findings of the current study could inform existing and future programmes to include more relevant and beneficial components to reduce levels of SA, for example, targeting the reduction of self-focused attention and dysfunctional cognitions, as well as increasing their ER ability. From an applied perspective, the present findings provide both significant and positive implications for the literature and social and emotion skill practices.

## **Chapter Six: Study Two**

### **The Effectiveness of a Newly Developed Intervention Programme for Social Anxiety Disorder in a Non-Clinical Child Population**

#### ***6.1 Overview***

This Chapter aims to present a quantitative study exploring the effectiveness of a newly developed emotional and social skills programme that focused on the reduction of Social Anxiety (SA) and the enhancement of Emotion Regulation (ER) in children and adolescents. Based on the findings of the previous study it seemed essential to include social and emotion enhancement skills combined with CBT components in a preventative fashion. The current study was conducted to address the need for more preventative programmes focussing on the reduction of SA and the development of SAD. Additionally, attention will be addressed to some of the existing inconsistencies in the available literature. This will be outlined further in the section below. A quantitative intervention study with a longitudinal design was utilised to determine the effectiveness of the newly developed programme for 8-11 year old children, while including input from their respective parents and teachers.

## *6.2 Introduction*

Anxiety disorders affect a large number of children and adolescents in the general population (15–31.9%; Essau et al., 2000; Merikangas et al., 2010) and cause significant distress and impairment in major areas of life. As a result, these disorders have a negative course, if left untreated, and may cause the onset of other disorders. Despite the number of scientifically significant treatments for the majority of child mental health problems (Goodman & Scott, 1997), only around 20% of children who are diagnosed with such disorders are in treatment (Meltzer, Gatward, Goodman, & Ford, 2000). Most prevention programmes conducted in schools focused on behavioural problems due to the disruptive nature of these difficulties (Gottfredson et al., 2000). Wilson and Lipsey (2007) propose the most effective and common approaches are the universal programmes, which are delivered to all students in a classroom and those focusing on targeted programmes for selected children outside their regular classrooms. These programmes mainly apply cognitive approaches so that the universality and the reasoning orientated methodology both seem to be indicators of this success. Thus, schools are an important location for interventions, in order to prevent or reduce psychological impairments (Wilson, & Lipsey, 2007).

One of the most recent transdiagnostic interventions employed within schools for anxiety and depression is the EMOTION: “Coping Kids” Managing Anxiety and Depression (Ehrenreich-May & Chu, 2014) for children aged 8 to 13. Although Martinsen, Kendall, Stark, and Neumer (2014) found the accessibility and feasibility of the programme to be highly significant and supported, the intervention is limited to symptoms of anxiety and depression rather than SAD. Furthermore, the authors did not include a comparison condition or a follow-up assessment to evaluate the efficacy of the programme, which limits the general application of their findings.

As the literature review outlined SAD is one of the most common psychological disorders affecting individuals from an early age and resulting in severe negative consequences in various aspects of life (e.g., Costello et al., 2011; Crozier et al., 2011; Hudson et al., 2010; Ollendick, 2009). Thus, paying attention to this disorder is of importance. An earlier pilot study by Masia and colleagues (2001) focused on SAD and examined the efficacy of the school-based behavioural treatment for SAD in adolescents. Their findings showed a significant reduction of SAD levels after an intervention as well as after treatment. This may suggest that the school setting is where adolescents with SAD endure the most distress and this, therefore, affects their behaviour. However, the findings of this study are limited to clinical samples and the shortcoming of including parents' and/or teachers' reports on the children, both limitations the current study aimed to address.

Furthermore, available research has shown maladaptive ER to be an underlying factor of SAD (e.g., Mennin et al., 2009; Spokas et al., 2009). In particular, the frequent suppression of emotions (Spokas et al., 2009; Werner & Gross, 2010) or avoidance (Kashdan & Breen, 2008; Werner et al., 2011), can have an adverse effect on sufferer's positive experiences (e.g., Kashdan & Collins, 2010) and positive assessment (Kashdan, Weeks, & Savostyanova, 2011; Weeks, Heimberg, & Rodebaugh, 2008). Studies with children and adolescents have found that ER skills enhance, among others, social competence and individuals' mental health (Gross & Muñoz, 1995; Kashdan & Farmer, 2014; Silvers et al., 2012). Thus, it is important to combine ER enhancement skills and CBT components. This has been supported by Suveg and colleagues (2006), who added an ER treatment component to an otherwise standard CBT programme for children with anxiety disorders and found overall positive results on the children's ability to identify



emotional states and understand ER strategies. However, the number of preventative psycho-educational programmes combining successful components of ER and CBT, in children with elevated levels of SA is low.

### *6.3 Rationale and Objectives*

Considering the high occurrence of SAD and related adverse effects (e.g., Hammerness et al., 2008; Kanai et al., 2009; Kühl et al., 2010; Tuschen-Caffier et al., 2011), there is a need to prevent the onset of SAD. Moreover, the early onset of SAD (e.g., Beidel & Turner, 2007; Dalrymple et al., 2007), the high prevalence (e.g., Kashdan & Herbert, 2001; Castello et al., 2011), and the rather low utilisation rate of programmes that treat or prevent SAD, in the first instance (Albano et al., 2003; Essau, 2005; Hope et al., 2006; Masia-Warner et al., 2005; Ruscio et al., 2008), stress the need for improvements or generally the development of more successful psycho-educational programmes that are more accessible, affordable, and effective in the long run.

Based on the literature review, the introduction of the current chapter, and the findings of the first study that highlighted the necessity of emotion and social enhancement skills, Study Two involved the implementation of a CBT-based emotion regulation and social skills enhancement programme for primary school children. The negative effects that SA had on an individual's performance and the significant correlations between SA, ER and self- and observer-ratings of the first study, informed the current research project aimed at reducing the levels of SA and increasing levels of ER. This was to be completed by focussing on improving social skills in children, increasing their emotion knowledge, and providing them with tools

to regulate negative emotions and thoughts that could be inhibiting in their daily lives.

The ESST-C (Essau, Keenan, Rowntree, & Pourseied, 2011) is novel in the fact that it is much shorter than existing programmes, easily accessible to school SENCO and staff, and it takes a multi-dimensional, psycho-educational approach. It is based on CBT principles and employs methods similar to those used in FRIENDS (Barrett, Lowry-Webster & Turner, 2000b), in which children are taught strategies to cope with anxiety and challenging situations (Essau et al., 2012; p. 455). However, the ESST-C focuses on the reduction and prevention of SAD by enhancing social and emotional skills. It was hoped that these skills enable children to deal with the challenges that they encounter in their daily lives. Furthermore, the programme is aimed at educating children about emotion and attentional control, thereby promoting a greater sense of self-awareness. It teaches children to correctly identify thoughts and emotions, accurately label them, and to obtain ways to change inhibiting emotional states and thoughts as well as to learn how to differentiate between what happens during diverse emotions on a cognitive, physiological, and behavioural level. In addition, participants will be taught to down-regulate the negative affect that tends to be inhibiting in social situations in particular. Thus, this will be pursued through both antecedent- and response-focused ER strategies such as cognitive reappraisal, mindfulness, positive self-talk, and PMR. Children will also be taught various social skills in order to reduce their fear and resulting avoidant behaviour towards social situations.

Thus, building on the aforementioned theoretical application of ER strategies (Gross, 2007), the current programme makes use of effective ER strategies such as reappraisal, while discouraging participants in the use of deleterious techniques such

as suppression. As discussed in the literature review, response-focussed strategies proved to be less effective and have more negative consequences on health than antecedent-focussed strategies (e.g., Flouri & Mavroveli, 2012; Haga et al., 2009; Hilt et al., 2010). Therefore, the programme focussed on teaching children the latter, while also offering tools for situations in which the emotion has already arisen. Children will be taught the ability to recognise and change maladaptive emotions and thoughts through antecedent strategies, such as reappraisal, positive self-talk, and PMR. Children will further be taught to cope with anxiety provoking situations, build emotional resilience, encourage peer learning, promote self-confidence and enhance emotional and social awareness. In addition, the group settings will enable young participants to learn from each other and support one another. Lastly, the ESST-C was offered in a preventative fashion to teach children a variety of different techniques that are valuable for possible challenges they may encounter. It is anticipated that the range of different techniques allows the child to choose the best technique most suitable to them on an individual level.

As presented and evaluated in the literature review, CBT is based on a talking cure that intends to solve problems concerning dysfunctional emotions, cognitions, and behaviours through a goal-orientated, systematic procedure. The main components are cognitive restructuring, relaxation exercises, exposure to feared situations, and reinforcement (Hitchcock et al., 2009). On that account, the focus on a training programme based on CBT as well as ER would not only help to control negative emotions, such as fear, but may further enhance the emotional awareness of oneself as well as others (e.g., Spence et al., 2000). As a result, the main objective of the proposed study is to examine the efficacy of a newly developed CBT- and ER-based programme focussed on the reduction of SA and behavioural difficulties and

the enhancement of ER levels in a preventive fashion. More concretely, the aim was to test whether the ESST-C increases ER skills and decreases levels of SA. Additionally, it aimed to test the relationship between (S)A, behavioural difficulties, and ER.

#### Hypotheses:

- (1) The ESST-C will increase levels of ER and decrease levels of SA and behavioural difficulties over time (EG only).
- (2) Girls compared to boys, and younger compared to older children, will benefit more from the ESST-C programme.
- (3) In comparison to children in the CG, children who participate in the ESST-C programme will report significantly lower levels of SA at three-month follow-up. In addition, children in the EG will show higher levels of ER than those in the CG.

## *6.4 Methodology*

### *6.4.1 Design*

This study utilised a quantitative method with a longitudinal design, aiming to determine the effectivity of a newly developed programme (independent variable) that focused on the reduction of SA and the enhancement of ER (dependent variables) in children and adolescents. Participants' levels of SA, behavioural difficulties, and ER were assessed at three different time points: firstly, at baseline (prior to the programme), secondly on completion of the six-week programme, and lastly at three-month follow-up. Participants of the control group (CG) however, were only assessed at baseline and at three-month follow-up, as they did not undergo the programme and thus, did not require the post measure assessment. Each measurement involved an identical questionnaire package measuring the child's levels of (social) anxiety, behavioural difficulties, and ER. For the purpose of the study, a number of Analyses of Variances (ANOVA) were conducted as well as correlation analyses to assess the relationship between different self-report and other-report measures of SA and ER. In particular, a mixed experimental design with age and gender as between-subject factors and time as a within-subject factor (pre-, post-programme, and three-month follow-up) for the experimental group (EG) solely was applied. Furthermore, a mixed experimental design with condition as a between-subject (EG vs. CG) and time as a within-subject factor (pre-programme and three-month follow-up) was employed. Finally, correlation analyses were conducted to present the link between SA, behavioural difficulties, and ER.

#### *6.4.2 Ethical Considerations*

Prior to the commencement of this study, ethical approval was obtained from the Ethical Board of the University of Roehampton (Appendix I). After ethical approval was obtained, schools were invited to participate in this study. The institutions interested in participation invited parents and children to take part in this study via their school's newsletter. Those parents who volunteered for the project were provided with a letter of invitation explaining the study (Appendix II or III) followed by a relevant consent form, which they were asked to complete for themselves and their children (Appendix V for EG and CG, in addition Appendix VI for EG). The forms (divided into the two phases of the study, as the second phase only applied to the EG) explained the primary objectives of the study in order to obtain informed consent, assuring participants that the information collected would be kept confidential, and to follow the University of Roehampton code of ethics.

#### *6.4.3 Participants*

Participants were 144 children (80 males, 64 females), aged 8 to 11 years (mean age=9.06 years; SD=0.95). A total of 85 children participated in the ESST-C program and 59 made up the CG. All participants of the current study were from Keystage two living in the south west area of London, UK. Participating schools responded to an email invitation to take part in an anxiety prevention research programme. Twenty schools from the Richmond Borough were invited to participate in the study; however, only eight schools confirmed their participation. Initially a total of 170 Children agreed to take part in this study; however four children left their school during the period of this study (two of which were in each condition), while further four children/parents withdrew their participation half way through the programme, and 18 children/parents withdrew their participation from the control

group, leaving the total sample size at 144. Children were randomly assigned to the intervention or control group and based on their parents' agreement.

With regard to the exclusion criteria, and for the purpose of the current study, children whose parents made us aware of any clinical diagnosis were excluded from the analyses. No children were known to have a clinical diagnosis of any kind, so the sample size was retained. In addition, the inclusion of children aged 8 to 11 only, was informed by existing research suggesting the age of onset for SAD to be between 7 – 13 years (e.g., Beidel & Turner, 2007; Costello et al., 2011; Knappe et al., 2011).

#### *6.4.4 Measures*

The *Emotion Regulation Index* for Children and Adolescents (ERICA; MacDermott et al., 2009). In the present study, the Cronbach's alpha for the ERICA was .770.

The *Social Phobia and Anxiety Inventory for Children* (SPAI-C; Beidel et al., 1995). In the present study the SPAI-C was employed as an initial screening measure as well as an index of change in social fears over the course of the training. The internal consistency of the SPAI-C in the present study was high, with a Cronbach's alpha of .96.

The *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 1997) for teachers (SDQ-T) and parents (SDQ-P). The internal consistency for the SDQ-T (teachers' report) was reputable at  $\alpha=.81$ , and for the SDQ-P (parents' report) at  $\alpha=.89$ .

See Study One for a detailed discussion of these questionnaires that were utilised for general data collections at baseline in Study One and at three time points in the current study. In addition to the above measures the following three measures were included in the second study:

The *Positive and Negative Affect Measure for Children* (PANAS-C, Watson, Clark & Carey, 1988). The PANAS-C is a 27 item self-report scale that measures positive affect and negative affect by scoring each item on a 5-point Likert scale ranging from 1 (not at all or very slightly) to 5 (extremely). The PANAS-C measures three factors of depression and anxiety: positive affect (expressing verbal and/or non-verbal positivity, being “in a good mood”), negative affect (expressing verbal and/or non-verbal negativity, being irritable or unhappy), and physiological hyper-arousal (physical manifestations of anxious feelings or hyper-vigilance such as racing heart, sweating, shallow breathing, difficulty relaxing, etc.). The total scores for positive affect and negative affect are summed separately to yield a total score for each scale. Higher scores signify higher levels of that specific emotional state (positive affect compared to negative affect). This psychometric tool is not only quickly administered but has also demonstrated strong internal reliability (Sohl & Moyer, 2009) and is commonly used in both mood and emotion research. In the current sample the Cronbach’s alpha for the PANAS was .83.

The *Spence Children Anxiety Scale* (SCAS; Spence, 1998) consists of 38 items, measuring anxiety symptoms in children and adolescents aged 7 - 19. Furthermore, the items replicate symptoms of the main DSM-IV anxiety disorders, including separation anxiety, social phobia, obsessive-compulsive disorder (OCD), panic disorder/agoraphobia, physical injury fear and generalized anxiety disorder (GAD). The items are rated on a 4-point scale from never (0) to always (3), whereby higher scores represent higher levels of anxiety symptoms. A total SCAS score is obtained by summing the 38 items that assess anxiety symptoms. However, for the purpose of the present study only the social phobia subscale (SCASSOC) was considered. Internal consistency and test-retest reliability of the SCAS have been



reported as satisfactory, with alphas generally well above .70 and a test-retest correlation coefficient of .60 (Spence, 1997). In the present study, the internal consistency of the SCAS was highly acceptable at  $\alpha=.92$ .

The *Spence-Children's Anxiety Scale, Parent Version* (SCAS-P; Spence, 1998) is a measure designed for parents to report on their child's levels of anxiety. The 38 items assess the frequency with which their child experiences each symptom, with ratings ranging from Never (scored 0) to Always (scored 4). The SCAS-P consists of six subscales: social phobia, separation anxiety, panic attack/agoraphobia, OCD, GAD, and physical injury fears. A total SCAS score is obtained by summing the 38 items. It has demonstrated good internal consistency with an overall coefficient alpha of .89 (.74 for the social phobia subscale). The entire SCAS was administered at baseline, post-treatment, and follow-up. The high level of internal consistency was confirmed in the current sample at  $\alpha=.85$ .

The *Follow-up Versions of the SDQ*, which include the 25 basic items and the impact question, in addition to two follow-up questions, for use after an intervention. In order to increase the probability of detecting subtle changes, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Each of these questionnaires has been used widely among children and adolescents due to their high validity and reliability (e.g., Beidel, Turner, Hamlin, & Morris, 2000; Essau, Muris & Ederer, 2002; Spence, Barrett & Turner, 2003; Voncken & Bögels, 2009). However, for the purpose of the current study, these scales were not used for clinical diagnosis; instead they were used purely for assessment purposes of behavioural difficulties and its correlation to ER. The internal consistencies of the SDQ-P ( $\alpha=.81$ ) and the SDQ-T ( $\alpha=.72$ ) in the current study were relatively high.

#### *6.4.5 The ESST-C Programme and its Implementation*

The ESST-C (Essau et al., 2011)<sup>3</sup> consists of six sessions, which are implemented once a week for the duration of six weeks. Each session consists of 45 minutes with six to eight children per treatment group. The initial session is devoted to education about self-esteem and self-evaluation. Children are taught to recognise different types of emotions and things they are good at. The second session focuses on different types of feelings, including activities where they had to recognise different feelings. The third session concentrates on thoughts. In both the second and third sessions children are being taught the link between feelings and thoughts with cognitive, behavioural, and physiological aspects of their anxiety. They are introduced to basic cognitive techniques, such as detecting and adjusting negative self-talk (e.g., helpful/unhelpful feelings & thoughts). The following, fourth, session links feelings, thoughts, and behaviour, the way they affect each other and themselves, as well as their body. Session five consists of identifying and learning about relaxation techniques, as well as “building skills” training (e.g., step by step approach). It further focuses on social skills (friendly/unfriendly behaviour, starting/ending conversations, etc.). The final session teaches children problem-solving steps in socially conflicting situations. This is taught as a strategy to address stressful and anxiety provoking situations, while emphasising general problem-solving steps. Table 6.1 provides a summarised description of the contents and activities of each session.

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<sup>3</sup> The ESST-C was developed by Professor Cecilia Essau, in collaboration with the Catholic Children's Society, and is partially funded by The Education, Children's and Cultural Services Directorate of the London Borough of Richmond upon Thames. Part of Study Two was part of an on-going research on the transdiagnostic intervention for childhood psychopathology; a project managed by Professor Cecilia Essau at the University of Roehampton.

Group leaders are asked to provide examples of certain scenarios amplifying the aim of each session, and utilise workbook exercises. Children are introduced to exposure exercises and other practices by demonstrations of possible scenarios, giving attention to cognitive, behavioural, and physiological experiences. Playful and experiential activities are used to generate multiple ideas for handling certain situations. Once the differences and variations among children's responses are revealed, they will begin to develop an understanding of the different ways in which everyone interprets and reacts to situations. In addition, children are given home activities that are reviewed and discussed at the beginning of each session. At the end of the programme they are provided with a certificate for participation and completion of the ESST-C programme as an incentive.

In the current study, children who missed a session of the programme were required to complete an individual session with their trainer before they could join the subsequent group session. A total of 17 children missed one group session, and further 3 missed two group sessions; all these children received an individual session before joining the next group session to ensure that all children participated in the entire ESST-C programme. Children were provided with an associated workbook to encourage the skills taught as well as the homework activities. Each group had a trained group leader as well as a school SENCO who shadowed the sessions and there were no more than 8 children in each group. All sessions followed an agenda: start with chat time and review the main point from the previous session, focus on a main activity for the present session, and the assignment of homework at the end of the session. Overall, the ESST-C presents a training programme to participants in a positive, safe environment, based on well-developed methods that have been critically reviewed and analysed in the existing literature.

All sessions are designed for implementation in schools and also include parent sessions. Parents were invited to two drop in sessions in order to discuss any questions or concerns they had. Additionally, they were informed about the content and progress of the sessions to assist them in supporting the maintenance of the skills acquired and enabling them to review their child outside of the school environment. Beyond these two sessions, a formal parent component was not included given the brevity of the programme. Approximately half of the parents, mostly mothers, participated in these sessions. Those parents who did not participate and gave a reason based this on a too demanding life style.

Table 6.1: Content and Activities of the ESST-C Programme for Children

Session	Aims	Activities
Session 1	To introduce group participants and to introduce the participants to the ESST-C.	Build rapport  Introducing the programme, agreeing on group rules, explaining home activities & reward system.
	To introduce the concept of self-esteem and to discuss situations that help enhance self-esteem.	Reading task, explain & discuss self-esteem.  Recognise, note and discuss strengths.
Session 2	To introduce participants to the concept of feelings.	Review session 1 & Home activity.  Introduction to feelings, reading task & open discussion. Recognising feelings tasks (facial expression & body language), face puzzle, feelings thermometer.
	To introduce participants to the concept of thought.	Listing different types of thoughts & discussing thought bubbles.
Session 3	To introduce participants to the concept of thought continued.	Review session 2 & Home activity.  Recognise HELPFUL and UNHELPFUL thoughts – reading task & group task on identifying these thoughts.
	To introduce the concept of the link between thoughts and feelings.	Challenging UNHELPFUL thoughts, reading task & group discussion. Discussing thoughts that help us feel GOOD.

**Table 6.1 (Continued)**

<b>Session</b>	<b>Aims</b>	<b>Activities</b>
Session 4	<p>To introduce the concept of the link between thoughts and feelings - continued.</p> <p>To teach children the important of relaxation and to teach them specific relaxation strategies.</p>	<p>Review session 3 &amp; Home activity. Link between thoughts and feelings, reading task. Individual &amp; group activities on thoughts &amp; feelings and active changing of both.</p> <p>Learning to Relax, reading task.</p> <p>Listing what happens when feeling relaxed &amp; tense</p>
Session 5	<p>To teach children the important of relaxation and to teach them specific relaxation strategies continued.</p> <p>To teach children various types of social skills.</p>	<p>Review session 4 &amp; Home activity.</p> <p>Various relaxation techniques taught through group activities.</p> <p>Building Skills group activity.</p> <p>Explanation &amp; group discussion on social skills. Reading activity on identification of FRIENDLY &amp; UNFRIENDLY behaviour. Role-play on friendly &amp; unfriendly behaviour in pairs. Role-play on first meetings &amp; how to approach people &amp; how to end conversations politely.</p>
Session 6	To teach children using problem-solving steps in dealing with social problem.	<p>Review session 5 &amp; Home activity.</p> <p>Introduce problem solving steps system. Reading task &amp; active appliance of problem solving steps in-group discussions. Role-play on social problem &amp; appliance of the acquired steps.</p>

Overall, the CBT aspect of the training programme is expected to teach children to:

- Cope with anxiety provoking situations
- Build emotional resilience
- Encourage peer learning
- Build peer support networks
- Promote self-confidence

In order to contribute to research that has focussed on these aspects of CBT, the current study included features of ER strategies. The focus on ER is expected to encourage children to develop an awareness of emotions experienced and the perspective of regulating them in the most beneficial way (Gross & Thompson, 2009). This was enhanced through:

- Cognitive Reappraisal: Participants are encouraged to focus on this ER strategy, which consists of the rearrangement of one's own, subjective interpretations of certain situations or environments, in order to modify its emotional impact (Gross, 2001). According to Koole (2009), this is usually done through the detachment of the "own" person from a distressing situation, in other words encouraging a more neutral (third-person) approach. In 1997, Stemmler found that cognitive reappraisal reduced physiological responses during a social interaction, while Nezlek and Kuppens (2008) suggested reappraisal of positive emotions to be linked to increased self-esteem, positive emotions and adjustments of the mind.
- Cognitive Restructuring: Participants are taught to identify negative thoughts and feelings that arise around a feared situation, challenge the accuracy of these

believes, and finally to develop alternative thoughts constructed from the acquired information (Heimberg, 2002). Additionally, participants are inspired to hold positive intrapersonal communication, as this has been associated with self-efficacy and higher task performance in physical education (Hardy et al., 2009; Kolovelonis, Goudas, & Dermitzaki, 2011). Thus, more positive wording in self-talk is anticipated; whereby positively directed sentences are aimed to be enhanced (e.g., “I can” rather than “I can’t”, etc.) as well as challenging unhelpful thoughts and feelings.

- Progressive muscle relaxation (PMR): Participants are asked to relax and tense their muscle in specific ways in order to attain maximal relaxation. Authors found that anxiety, perceived stress levels, and resulting levels of high blood pressure decreased through PMR (e.g., Sheu et al., 2003; Rausch et al., 2006), supporting its benefits.

In summary, the methods of delivery applied in this training programme for the children consisted of interactive exercises, role-play, and home activities, as well as the involvement of their parents to ensure the successful adaptations outside of the school environment.

#### *6.4.6 Procedure*

Twenty schools of the Borough of Richmond were recruited via an email invitation explaining the purpose and procedures of the current study. In total, eight schools confirmed their participation in this programme. Once schools had confirmed their participation teachers, SENCO’s, and deputy heads who were identified by the head of the schools were released from classroom duties for one full day to complete an intensive workshop covering the principles and practices of prevention and early



intervention. In addition, the workshop covered the entire manual of the ESST-C programme. This session was delivered by the director of this study (Professor C.A. Essau).

Children and parents were invited to take part in this study through the participating school's newsletter. Interested parents and children were provided with either the letter of invitation for the intervention (Appendix II) or control group (Appendix III) at random, outlining the aims and objectives of the project. Parents who continued to express their interest in participating were further advised that the questionnaires in this study are designed simply to look at typical variation in aspects of ER and challenging situation, and not used as tools to diagnose a mental illness. Parents were then provided with the relevant consent form (Appendix V for both groups, and an additional consent form for the intervention group, Appendix VI), which they were asked to sign and return. A consent rate of 91 was obtained for the intervention and 79 for the control group condition, however four children left their school during the course of this study (two of which were in each condition), while further four withdrew their participation from the intervention and 18 children/parents withdrew their participation from the control group condition. Thus, 85 children made up the intervention group and 59 children the control group. The programme was delivered by graduate students, who were checked and cleared by the Disclosure and Barring Service (DBW; previously Criminal Records Bureau, CRB), prior to the commencement of this programme. They were trained and equipped with on-going agenda protocols for each session (Essau et al., 2011). All group trainers were required to adhere to this instruction protocol clearly outlined in the Trainer's Manual (Essau et al., 2011). The instructors were also asked to provide general feedback on each session on the child's presence and home activity status.

The instructions described the aims and strategies for each session, the desired outcomes, and the specific exercises to be used in meeting these outcomes. All group leaders and the member of school-staff shadowing were provided with the ESST-C manual. The workbook allowed participants to apply each of the skills taught to their own life situation. To reinforce and generalise the skills introduced in the sessions, home activities were assigned to each meeting and participants were required to return these completed in the following sessions.

In the consent forms participants were informed that the purpose of the study was to further our understanding of how children respond to social situations and how it can affect their cognition, emotional state, as well as their social skills. SA was not mentioned. Following informed consent, and prior to the beginning of the group intervention, children participated in an initial session with the main investigator, with a teacher present, completing a set of questionnaires. These questionnaires also requested demographic information such as age and gender. Children were informed that they were randomly chosen for this group, which is anticipated to be delivered to other children too, in order to avoid any feeling of exclusion or stigmatisation. Children completed the baseline self-report questionnaires (ERICA, SPAI-C, SCAS-C, and PANAS-C) within normal class time. All students were asked to sit at their own desk and to listen carefully to the instructions that were provided. The main investigator of this study (MSc and BSc Psychology graduate) read the instructions of each questionnaire aloud to all children and assisted children who had difficulties understanding some of the words or questions throughout. Children were informed that all questionnaire responses were confidential and that there were no right or wrong answers. Parents completed two questionnaires per child (SDQ-P, SCAS-P), while the teachers completed one

questionnaire per child (SDQ-T). The assessments were all taken within the same week from the children, parents, and teachers to ensure the accuracy of the child's levels of SA and ER prior to the training.

Following the pre-treatment assessment, children allocated to the experimental group engaged in the six-week ESST-C Programme. At the end of the programme, children and parents were asked to complete the post-treatment assessments as well as evaluation sheets for the programme to assess their general satisfaction of the course (Appendices XVII, XVIII). The post-programme measures consisted of the same questionnaires for the children and parents, except that parents were asked to complete the follow-up version of the SDQ-P in addition to the SCAS-P and their teachers were asked to complete the SDQ-T follow-up version, in order to assess the efficacy of the training programme. Identical to the pre- and post-programme assessment, the children completed their questionnaires for the three-month follow-up, within school hours, in the school administered by the main investigator of this study. The parents and teachers questionnaires were sent or handed to them for completion and returned within two weeks. Children assigned to the CG were assessed over the same interval as the children in the intervention group, except during the 2<sup>nd</sup> assessment point. As they did not go through the training programme, there was no requirement to assess the measures immediately after the programme. On completion of the programme, children were provided with a certificate of participation and at the end of each session with stickers as an incentive. Parents were informed that their children would be taught specific skills that they could use to better cope with challenging and anxiety-provoking situations, both now and in the future, if the results of this study demonstrated significance. Finally, all participants were fully debriefed.

#### *6.4.7 Debriefing*

At the end of the study, participants were debriefed verbally and in writing. Each parent that had participated and allowed their child to participate received a debrief form that discussed the nature of the study. It was also reiterated that, all information obtained during the study would remain confidential. If the participants had any further concerns regarding the study they were advised to contact the principle investigator, the schools' SENCO, the Director of Studies, and/or the Head of the Psychology Department (see appendices VII and VIII).

#### *6.4.8 Data Analyses*

Initially, descriptive statistics were calculated for both the control and experimental group before, during, and after the completion of the programme. This was followed by two separate ANOVA's:

A mixed 2x2 ANOVA (EG vs. CG) as the between-subjects variable and time (baseline vs. 3-month follow-up) as the within-subjects variable was conducted to detect the effect of the ESST-C programme on ER (ERICA, PANAS), anxiety (SCAS-C, SCAS-P), SA (SPAI-C), and emotional and behavioural difficulties (SDQ-P, SDQ-T). In addition, a mixed 2x2x3 ANOVA with gender and age as the between-subjects variable and time (baseline vs. post-intervention vs. 3-month follow-up) as the within-subjects variable on the EG only was conducted on participants' ratings of various measures over time. Furthermore, Post-hoc analyses were conducted to investigate intra- and inter-group differences over time. Lastly, Bonferroni corrected Pearson correlations were performed to assess the relationships between SA, behavioural difficulties, and ER.

## **6.5 Results**

### **6.5.1 Preliminary Analysis**

Prior to statistical analyses, the data were screened for the presence of outliers and violations of the assumptions of ANOVA. Some outliers existed, however, considering the fact that these were legitimate cases and did not appear to be the result of coding mistakes, their deletion did not have a significant impact on the results. They were, therefore, retained in the analyses and solely transformed to maintain the sample size. An examination of the distributions of the continuous measures revealed significant skewness and in some cases significant kurtosis due to the significant outliers among some of the outcome measures. For this reason, different types of transformation were conducted and, in view of the advantages and disadvantages of each of them, the most suitable transformation was utilised. Considering the nature of outliers it was legitimate to adjust the score to be one unit above/below the next highest/lowest score in the sample, which is not an extreme score. This is justifiable as most statistical techniques use the mean (a measure of the average or most typical score), which is affected by outliers (Dancey & Reidy, 2004, in Tabachnick & Fidell, 2007). Although some of the data remained skewed and included negative or positive kurtosis post-transformation, based on Tabachnick and Fidell (2007), it is legitimate to proceed with parametric tests, considering the relatively large sample size. The standard errors for both skewness and kurtosis decrease with larger N, as a result the null hypothesis is likely to be rejected with large samples when there are only minor deviations from normality. According to Tabachnick and Fidell (2007; p. 74), “In a large sample a variable with statistically

significant skewness often does not deviate enough from normality to make a substantive difference in the analysis”.

Descriptives for outcome measures at baseline (pre-test), post-test, and follow-up test are presented in Table 6.2. The data were screened for the presence of outliers and missing values. As a rule of thumb, no more than 15% of the missing items on a scale were allowed to be included in the analysis. Some parents’ and teachers’ questionnaires were missing completely for some children and were therefore omitted from the analyses according to the pair-wise deletion. Missing data were less than 15% across all participants and measures (ranging from 2.4% to 15% for the SCAS and the SDQ questionnaires, and 2.4% for the ERICA, PANAS, and SPAI-C questionnaires). With <15 % missing, the missing value was replaced by calculating the mean of each subscale total of that individual and replacing the missing value with the result of this. The replacement of missing values with relevant subscale mean scores is considered a statistically conservative approach (Field, 2005).

Note. Due to some missing data that could not be imputed, Ns vary for some of the groups, ranging from 72-85 for the EG and 51-59 for the CG.

Table 6.2: Means and Standard Deviations of Self-Report Measures for Children in the EG and CG

Variables	Pre-test	Post-test	3-Month Follow-up
	Mean (SD)	Mean (SD)	Mean (SD)
<i>1) ERICA (Total scores)</i>	Child	Child	Child
<b>Prevention</b>	57.59 (8.83)	58.33 (9.01)	59.57 (8.81)
<b>Control</b>	60.59 (6.69)		62.00 (7.65)
<i>Emotional Control</i>			
<b>Prevention</b>	23.60 (5.84)	23.91 (6.61)	24.41 (5.93)
<b>Control</b>	24.14 (4.29)		24.86 (4.6)
<i>Emotional S-Awareness</i>			
<b>Prevention</b>	17.73 (2.83)	18.41 (3.57)	18.35 (2.88)
<b>Control</b>	18.97 (2.75)		19.78 (2.64)
<i>Sit. Responsiveness</i>			
<b>Prevention</b>	16.26 (2.65)	16.01 (2.56)	16.81 (2.64)
<b>Control</b>	17.49 (1.76)		17.36 (2.18)

Table 6.2 continued			
Variables	Pre-test	Post-test	3-Month Follow-up
	Mean (SD)	Mean (SD)	Mean (SD)
2) <i>PANAS</i>	Child	Child	Child
<i>Positive Affect Scale</i>			
Prevention	41.15 (9.95)	43.27 (10.70)	42.90 (10.5)
Control	46.88 (9.94)		46.93 (8.64)
<i>Negative Affect Scale</i>			
Prevention	28.49 (10.42)	26.33 (12.60)	26.52 (10.01)
Control	24.00 (9.09)		23.08 (7.94)
3) <i>SPAI-C</i>			
Prevention	16.20 (10.34)	13.65 (11.03)	12.69 (8.83)
Control	13.39 (7.94)		11.05 (8.15)



Table 6.2 continued

Variables	Pre-test		Post-test		3-Month Follow-up	
	Mean (SD)		Mean (SD)		Mean (SD)	
<b>4) SCAS (Total scores)</b>	Child	Parent	Child	Parent	Child	Parent
<b>Prevention</b>	22.46 (14.00)	20.55 (11.40)	22.61 (18.26)	16.54 (10.70)	20.42 (15.60)	15.50 (10.03)
<b>Control</b>	17.29 (11.23)	16.19 (12.45)			15.88 (12.74)	14.18 (12.33)
<i><b>Social Phobia</b></i>						
<b>Prevention</b>	5.06 (3.49)	6.07 (3.28)	4.91 (3.92)	5.21 (3.52)	4.47 (3.48)	4.81 (2.97)
<b>Control</b>	3.98 (2.89)	4.39 (3.29)			3.68 (2.82)	3.73 (3.05)
<b>5) SDQ (Total scores)</b>	Parent	Teacher	Parent	Teacher	Parent	Teacher
<b>Prevention</b>	12.90 (8.67)	10.24 (7.35)	10.13 (7.16)	9.46 (7.35)	10.64 (7.58)	9.86 (7.36)
<b>Control</b>	8.20 (5.14)	4.47 (4.54)			7.27 (4.44)	5.11 (4.50)
<i><b>Emotional Symptoms</b></i>						
<b>Prevention</b>	3.57 (2.86)	2.53 (2.49)	2.76 (2.38)	2.35 (2.23)	2.76 (2.38)	2.55 (2.53)
<b>Control</b>	1.97 (2.35)	1.11 (1.88)			1.62 (1.9)	1.32 (2.11)

Table 6.2 continued

Variables	Pre-test		Post-test		3-Month Follow-up	
	Mean (SD)		Mean (SD)		Mean (SD)	
<b>Conduct Problem</b>	Parent	Teacher	Parent	Teacher	Parent	Teacher
<b>Prevention</b>	2.28 (2.28)	1.39 (1.79)	1.74 (1.99)	1.25 (1.83)	1.89 (2.21)	1.31 (2.01)
<b>Control</b>	1.47 (1.48)	0.58 (1.07)			1.27 (1.25)	0.68 (1.29)
<i>Hyperactivity/Inattention</i>						
<b>Prevention</b>	4.35 (3.09)	4.08 (3.55)	3.78 (2.94)	3.74 (3.39)	3.65 (3.13)	3.77 (3.38)
<b>Control</b>	3.42 (2.42)	1.16 (1.54)			3.27 (2.51)	1.63 (1.98)
<i>Peer Problems</i>						
<b>Prevention</b>	2.71 (2.25)	2.24 (2.33)	2.06 (2.2)	2.12 (2.27)	2.33 (2.14)	2.22 (2.12)
<b>Control</b>	1.34 (1.66)	1.63 (2.09)			1.12 (1.49)	1.47 (1.74)
<i>Pro-Social Behaviour</i>						
<b>Prevention</b>	7.7 (2.46)	7.19 (2.58)	7.97 (1.89)	7.36 (2.48)	8.1 (2.07)	7.24 (2.37)
<b>Control</b>	8.07 (2.01)	8.16 (2.89)			7.92 (2.01)	8.26 (2.13)

**Table 6.2 continued**

Variables	Pre-test		Post-test		3-Month Follow-up	
	Mean (SD)		Mean (SD)		Mean (SD)	
<b>Impact Scale</b>	Parent	Teacher	Parent	Teacher	Parent	Teacher
<b>Prevention</b>	4.6 (4.28)	2.63 (2.6)	5.41 (2.19)	3.69 (2.03)	6.09 (2.69)	4.18 (1.9)
<b>Control</b>	1.27 (2.12)	1.11 (2.49)			3.69 (2.43)	3.4 (1.67)

*Note. ERICA=Emotion Regulation Index for Children and Adolescents; PANAS=Positive and Negative Affect Scale; SPAI-C=Social Phobia and Anxiety Inventory for Children; SCAS=The Spence Children's Anxiety Scale; SDQ=Strengths and Difficulties Questionnaire; Control group measures were taken at T1 and T3 only. Children Prevention Group: n = 85 across all measures and across all time points except at T3, n = 83; Children Control Group: n = 59 across all measures and time points; Parents Prevention Group across all measures: n = 83 at T1, n = 72 at T2 and T3; Parents Control Group across all measures: n = 59 at T1, n = 52 at T3; Teachers Prevention Group n = 85 across T1 and T2 and n = 83 at T3; Teachers Control Group n = 19 across all time points. Gender Prevention Group Females n = 39, Males n = 46; Gender Control Group Females n = 25, Males n = 34; Age Prevention Group Younger n = 62, Older n = 23; Age Control Group Younger n = 37, Older n = 22.*

## Pre-Prevention Correlations

Table 6.3:

Correlations between SA, ER and Children's, Parents', and Teachers' Report at Baseline (T1)

Variables	ERICA	Positive Affect Scale	Negative Affect Scale	SCAS-C	SCAS-SOC	SPAI-C	SCAS-P	SDQ-P	SDQ-T
<b>ERICA</b>									
<b>Positive Affect Scale</b>	.36***								
<b>Negative Affect Scale</b>	-.44***	-.20**							
<b>SCAS-C</b>	-.26***	-.01	.57***						
<b>SCASSOC</b>	-.19**	-.11	.48***	.82***					
<b>SPAI-C</b>	-.18*	-.04	.42***	.65***	.56***				
<b>SCAS-P</b>	-.17*	-.28***	.28***	.39***	.33***	.26***			
<b>SDQ-P</b>	-.47***	-.30***	.34***	.27***	.27***	.06	.58***		
<b>SDQ-T</b>	-.54***	-.30***	.29***	.26**	.20*	.13	.47***	.73***	

Note: One-tailed \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ . ERICA= Emotion Regulation Index for Children and Adolescents; SPAI-C= Social Phobia and Anxiety Inventory for Children; SCAS-C=The Spence Children's Anxiety Scale; SCASSOC = The Social Anxiety Subscale of the Spence Children's Anxiety Scale; SCAS-P=The Spence Children's Anxiety Scale – Parent version; SDQ-P= Strengths and Difficulties Questionnaire – Parent version; SDQ-T= Strengths and Difficulties Questionnaire – Teacher version

Table 6.2 includes the descriptive statistics for all psychometric questionnaires utilised during pre- and post- data collections for both treatment and control conditions. The questionnaires measured SA, anxiety, behavioural difficulties, and ER. All variables demonstrated high reliability ranging from 0.80 to 0.96 as measured by Cronbach's Alpha. In particular, the reliability within the experimental group was good ranging from 0.73 to 0.98 and in the control group variables also demonstrated reliability ranging from 0.62 to 0.96, as measured by Cronbach's Alpha. The only exceptions were found in the control group on the SDQ-T measures

(pre-training  $\alpha = 0.14$ , three-month follow-up  $\alpha = 0.46$ ), which may have been due to many missing teachers' questionnaires.

Table 6.3 presents the results of the Bonferroni corrected, bivariate correlations between SA (SPAI-C, SCASSOC), ER (ERICA and PANAS), anxiety (as per children's report SCAS-C; and parents' report SCAS-P), and behavioural difficulties (as per parents' (SDQ-P) and teachers' report (SDQ-T) at Baseline (T1). Results suggested low levels of ER (ERICA) to be associated with low levels of Positive Affect and high levels of Negative Affect, while low levels of ER were linked with high levels of anxiety (as measured by parents as well as children, SCAS) and high levels of SA (SPAI-C, SCASSOC). Similarly, low levels of ER were related to high levels of behavioural difficulties (as measured by parents and teachers, SDQ).

Moreover, high levels of anxiety (SCAS-C, SCAS-P), SA (SPAI-C, SCASSOC), and behavioural difficulties (SDQ-P, SDQ-T) were associated with high levels of Negative Affect (NA of the PANAS) and low levels of Positive Affect (PA of the PANAS, though PA did not significantly correlate with SA levels). Lastly, high levels of SA (SPAI-C, SCASSOC) were associated with high levels of anxiety (as measured by parents, SCAS-P) and behavioural difficulties (as measured by parents and teachers, SDQ). In addition positive correlations were demonstrated between anxiety scores, as measured by children (SCAS-C) and anxiety scores, as measured by parents (SCAS-P), as well as between anxiety and SA (SPAI-C) and behavioural difficulties (SDQ-P, SDQ-T).

### *6.5.2 Hypothesis 1 & 2: Analysis of Variances for EG only*

85 participants (39 female, 46 male) took part in the programme. The participants ranged in age from 8 to 11 ( $M = 9.02$ ,  $SD = .82$ ).

A Mixed 2x2x3 ANOVA with gender (male ( $n=46$ ) vs. female ( $n=39$ )) and age (high ( $n=23$ ) vs. low ( $n=62$ )) as the between-subjects variable and time (baseline vs. post-intervention vs. 3-month follow-up) as the within-subjects variable was conducted on participants' ratings of various measures over time. In addition Post-hoc analyses were conducted to investigate intra- and inter-group differences over time.

*Main effects of time, gender and age on emotion regulation (ERICA, PANAS):*

#### *ERICA*

The results show that there was a significant main effect of Time,  $F(2,158) = 3.54$ ,  $p=.031$ ,  $\eta^2 = .04$ , but no significant main effect of gender or age, and no significant time by age interaction ( $F < 1$  and  $p > .1$ ). Inspection of the means indicated that ERICA scores differed across time (T1:  $M = 57.59$ ,  $SD = 8.83$ , T2:  $M = 58.33$ ,  $SD = 9.01$ , T3:  $M = 59.57$ ,  $SD = 8.81$ ). Figure 6.1 further illustrates that ERICA levels increased immediately after the programme and further at three-month follow-up.

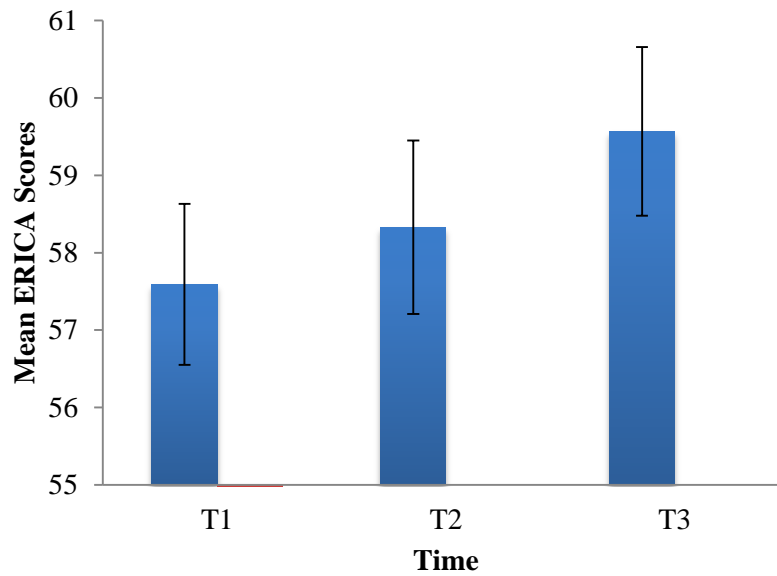


Figure 6.1: ERICA Scores across Time. Error bars represent standard error.

Post hoc Comparisons (using Bonferroni correction (adjusted alpha level of 0.01 per test)) revealed a significant difference between T1 and T3,  $t(82) = -2.57, p = .01$  (T1:  $M = 57.59, SD = 8.83$ ; T3:  $M = 59.57, SD = 8.81$ ), and non-significant differences across other times ( $p > .01$ ), indicating an increase in levels of ER from pre-intervention (T1) to three month-follow up (T3).

There was a significant Time x Gender interaction,  $F(2,158) = 3.65, p = .028, \eta^2 = .044$ , indicating a significant difference between boys and girls in ER levels across time (Boys T1:  $M = 55.41, SD = 8.56$ , T2:  $M = 58.33, SD = 9.80$ , T3:  $M = 58.76, SD = 9.20$ ; Girls T1:  $M = 59.95, SD = 8.27$ , T2:  $M = 58.22, SD = 8.13$ , T3:  $M = 60.57, SD = 8.31$ ). These means, further illustrated in Figure 6.2, indicate higher levels of ER at baseline in females as opposed to males, at time two these levels decrease in females but increase in males and at three month follow-up the girls present higher levels of ER again compared to the boys, demonstrating the benefits of the programme on levels of ER in both boys and girls.

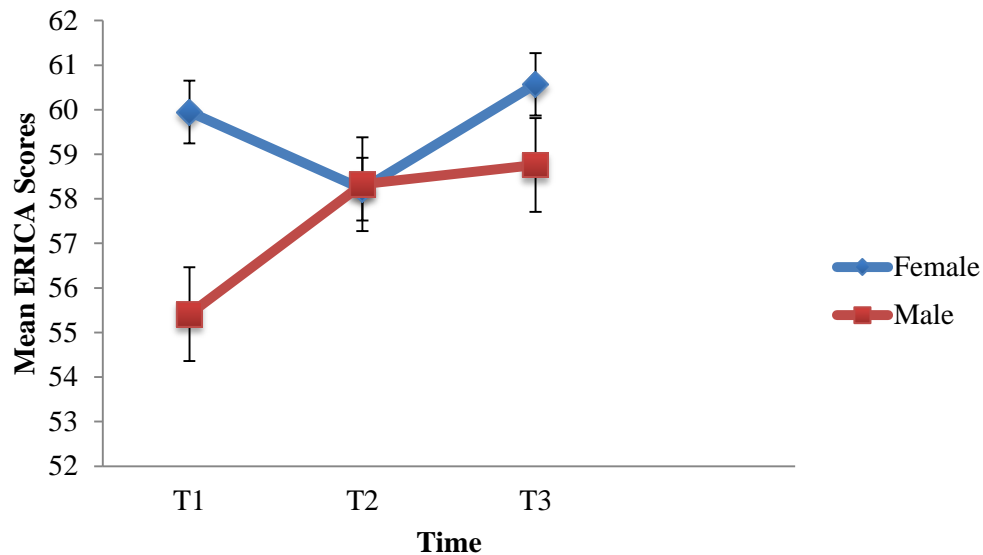


Figure 6.2: ERICA Scores across Time by Gender. Error bars represent standard error.

Using Bonferroni correction (BC; adjusted alpha level of 0.01 per test) post hoc comparisons were carried out to detect any differences in mean time scores between males and females.

Post hoc Comparisons revealed a non-significant difference between girls and boys at baseline on the ERICA scores,  $t(83) = 2.55, p = .013$  (Females:  $M = 59.95, SD = 8.27$ ; Males:  $M = 55.41, SD = 8.56$ ) after BC. The mean scores however, show higher scores for girls than boys on ER scores at baseline.

After BC there was no longer a significant difference between T2 (post-intervention) and T3 (3 month's follow-up) in girls,  $t(36) = -2.6, p = .013$  (from  $M = 58.22, SD = 8.13$  to  $M = 60.57, SD = 8.31$ ). However, the mean scores show an increase in ER scores three month after the prevention.

There was a significant difference between T1 (pre-intervention) and T2 (post-intervention) between boys,  $t(45) = -3.32, p = .002$  (from  $M = 55.41, SD = 8.56$  to  $M = 58.33, SD = 9.80$ ) and T1 (pre-intervention) and T3 (3 month's follow-up),



$t(45) = -3.46, p = .001$  (from  $M = 55.41, SD = 8.56$  to  $M = 58.76, SD = 9.20$ ), indicating an increase of ER levels immediately after the prevention and that levels of ER continued to increase at three month's follow-up after the prevention had occurred, supporting the benefits of the programme for boys (after BC).

### *PANAS-Positive Affect Scale*

There was a significant main effect of Age on Positive Affect scores,  $F(1,79) = 5.16, p = .026, \eta^2 = .06$ , but no significant main effects for time or gender on Positive Affect scores and no significant interactions between time and gender and time and age ( $F < 1$  and  $p > .1$ ). Inspection of the means indicated that there was a difference in PA scores between younger and older children (Younger:  $M = 41.01, SD = 10.31$ ; Older:  $M = 45.55, SD = 9.45$ ). This is further presented in Figure 6.3, where higher Positive Affect scores are shown in older compared to younger children.

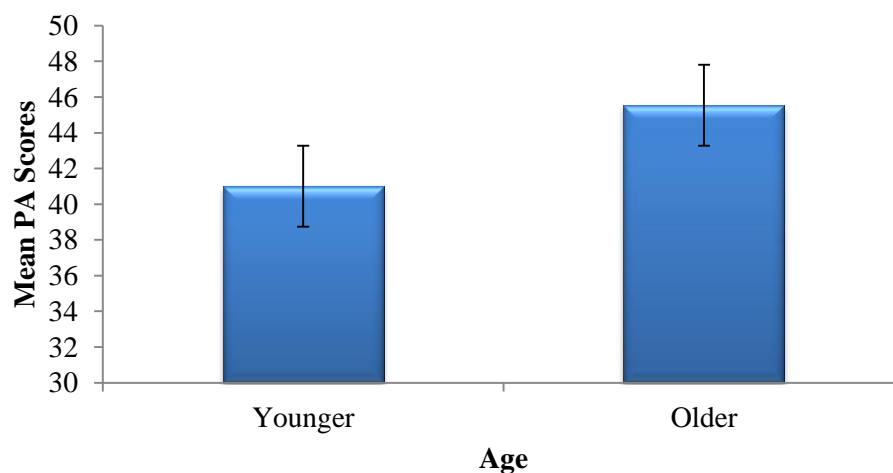


Figure 6.3: Positive Affect Scores by Age. Error bars represent standard error.

### *PANAS-Negative Affect Scale*

There were no significant main effects of time, age, or gender and no significant interactions of time and gender, and time and age on the Negative Affect scores ( $F < 1$  and  $p > .1$ ).

### *Main effects of time, gender and age on social anxiety (SPAI-C):*

There was a significant main effect of Time on SPAI-C,  $F(2,158) = 7.6$ ,  $p = .001$ ,  $\eta^2 = .09$ , indicating a significant change in levels of SA over time (T1:  $M = 16.20$ ,  $SD = 10.34$ , T2:  $M = 13.65$ ,  $SD = 11.03$ , T3:  $M = 12.69$ ,  $SD = 8.83$ ). These means, further illustrated in Figure 6.4, show a decrease in SA scores immediately after and at three-month follow-up. There were no significant main effects of gender or age and no significant interactions of time and gender, and time and age on the SPAI-C scores ( $F < 1$  and  $p > .1$ ).

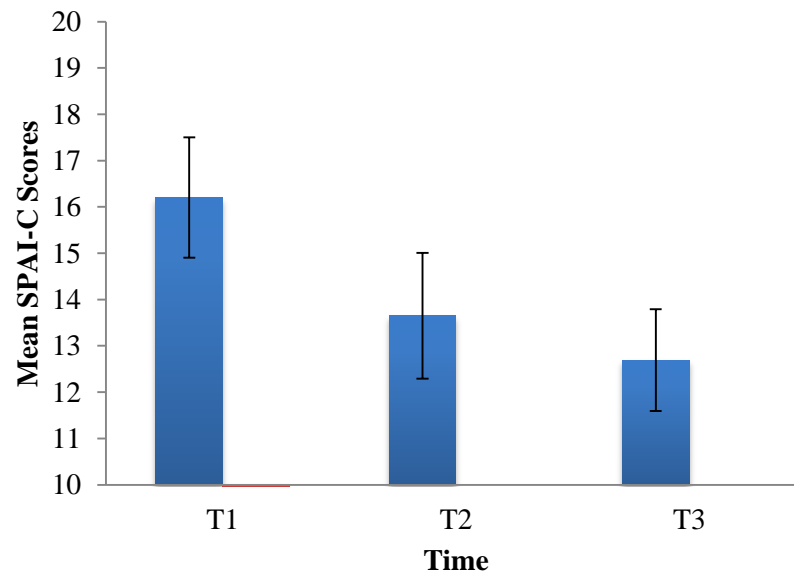


Figure 6.4: SPAI-C Scores across Time. Levels of SA before (T1), after the programme (T2), and at three-month follow-up (T3). Error bars represent standard error.

Post hoc Comparisons (using Bonferroni correction (adjusted alpha level of 0.01 per test)) revealed a significant difference between T1 and T2,  $t(84) = 2.61, p < .01$  (T1:  $M = 16.20, SD = 10.34$ ; T2:  $M = 13.65, SD = 11.03$ ), T1 and T3,  $t(82) = 3.57, p < .01$  (T1:  $M = 16.20, SD = 10.34$ ; T3:  $M = 12.69, SD = 8.83$ ), indicating that levels of SA as measured by children's report (SPAI-C) decreased significantly from pre-intervention (T1) to post-intervention (T2) and pre-intervention (T1) to three month follow-up (T3).

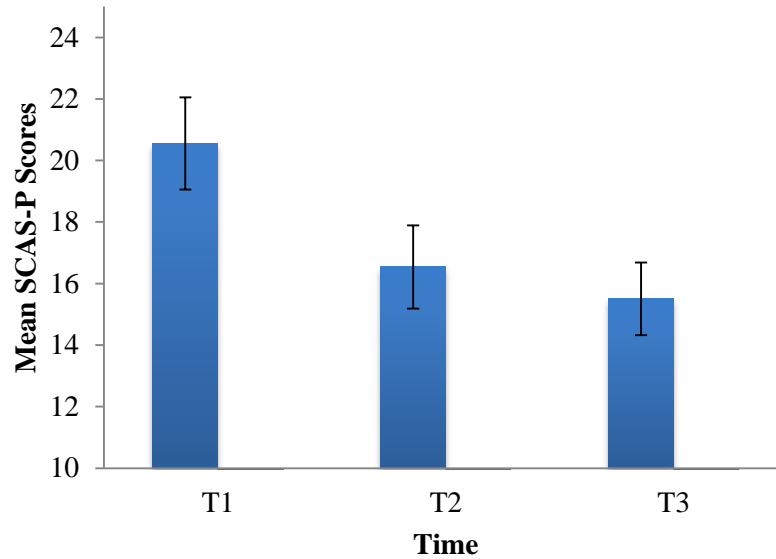
*Main effects of time, gender and age on anxiety (SCAS, SCAS-P):*

#### *SCAS-C*

There were no significant main effects of time, age, or gender and no significant interactions of time and gender, and time and age on the SCAS-C scores ( $F < 1$  and  $p > .1$ ).

#### *SCAS-P*

There was a significant main effect of Time on SCAS-P,  $F(1.92,136) = 20.67, p < .001$ , indicating a significant change in levels of anxiety over time as per parents' report (T1:  $M = 20.55, SD = 11.40$ , T2:  $M = 16.54, SD = 10.70$ , T3:  $M = 15.50, SD = 10.03$ ). These means, further illustrated in Figure 6.5, suggest a decrease in anxiety levels as per parents' report immediately after the programme and at three-month follow-up. There were no significant main effects of gender or age and no significant interactions of time and gender, and time and age on the SCAS-P scores ( $F < 1$  and  $p > .1$ ).



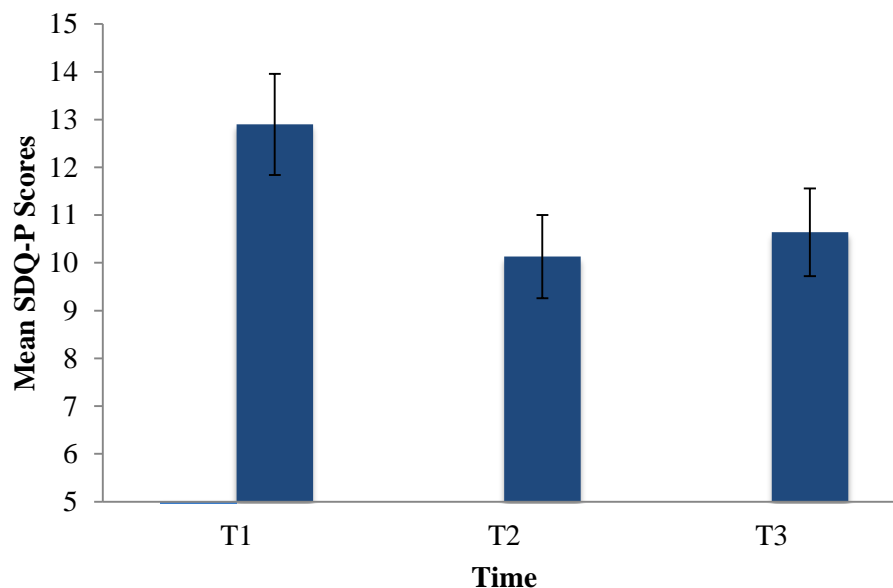
*Figure 6.5: SCAS-P Scores across Time. Levels of anxiety before (T1), after the programme (T2), and at three-month follow-up (T3). Error bars represent standard error.*

Post hoc Comparisons (using Bonferroni correction (BC; adjusted alpha level of 0.01 per test)) revealed a significant difference between T1 and T2,  $t(71) = 4.31, p < .005$  (T1:  $M = 20.55, SD = 11.40$ ; T2:  $M = 16.54, SD = 10.70$ ) and T1 and T3,  $t(71) = 6.55, p < .005$  (T1:  $M = 20.55, SD = 11.40$ ; T3:  $M = 15.50, SD = 10.03$ ), indicating that anxiety levels as measured by parents' report (SCAS-P) decreased significantly from pre-intervention (T1) to post-intervention (T2) and from T1 to three month follow-up (T3).

*Main effects of time, gender and age on emotional and behavioural difficulties (SDQ-P, SDQ-T):*

#### *SDQ-P*

There was a significant main effect of Time on the SDQ-P,  $F(2,136) = 14.14$ ,  $p < .001$ , indicating a significant difference on negative attributes over time (T1:  $M = 12.90$ ,  $SD = 8.67$ , T2:  $M = 10.13$ ,  $SD = 7.16$ , T3:  $M = 10.64$ ,  $SD = 7.58$ ). These means, further illustrated in Figure 6.6, suggest a decrease in negative attributes immediately after the programme but a slight increase again at three-month follow-up, yet the increase is still lower than at baseline. There were no significant main effects of gender, and no significant interactions of time and gender, and time and age on the SDQ-P scores ( $F < 1$  and  $p > .1$ ).



*Figure 6.6: SDQ-P Scores across Time. Levels of behavioural difficulties before (T1), after the programme (T2), and at three-month follow-up (T3). Error bars represent standard error.*

Post hoc Comparisons (using Bonferroni correction (adjusted alpha level of 0.01 per test)) revealed a significant difference between T1 and T2,  $t(71) = 4.82, p < .005$  (T1:  $M = 12.90, SD = 8.67$ ; T2:  $M = 10.13, SD = 7.16$ ), as well as between T1 and T3,  $t(71) = 4.07, p < .005$  (T1:  $M = 12.90, SD = 8.67$ ; T3:  $M = 10.64, SD = 7.58$ ), indicating that levels of behavioural difficulties as measured by parents' report (SDQ-P) decreased significantly from pre-intervention (T1) to post intervention (T2) as well as pre-intervention (T1) to three month follow-up (T3).

There was a significant main effect of Age on the SDQ-P,  $F(1,68) = 9.17, p = .003$ , indicating a significant difference on behavioural difficulties in younger compared to older children. Inspection of the means suggests lower levels of behavioural difficulties as reported by parents in younger as opposed to older children (Younger:  $M = 9.52, SD = 6.62$ ; Older:  $M = 14.65, SD = 9.10$ ). This is further illustrated in Figure 6.7.

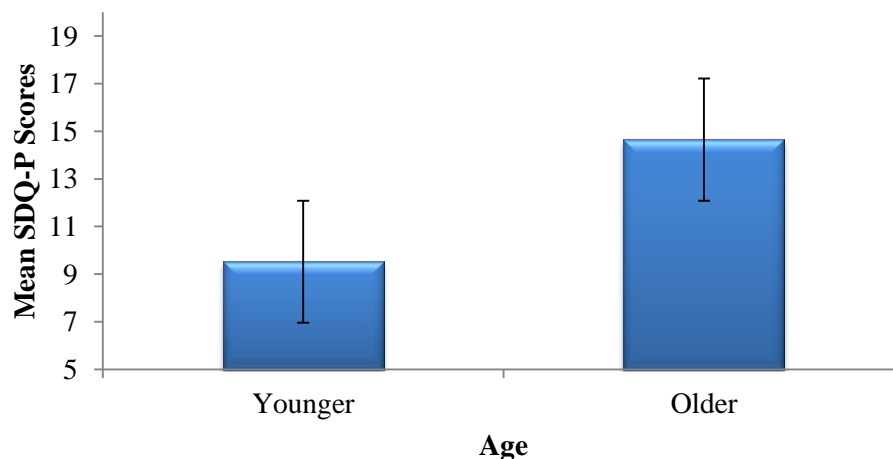
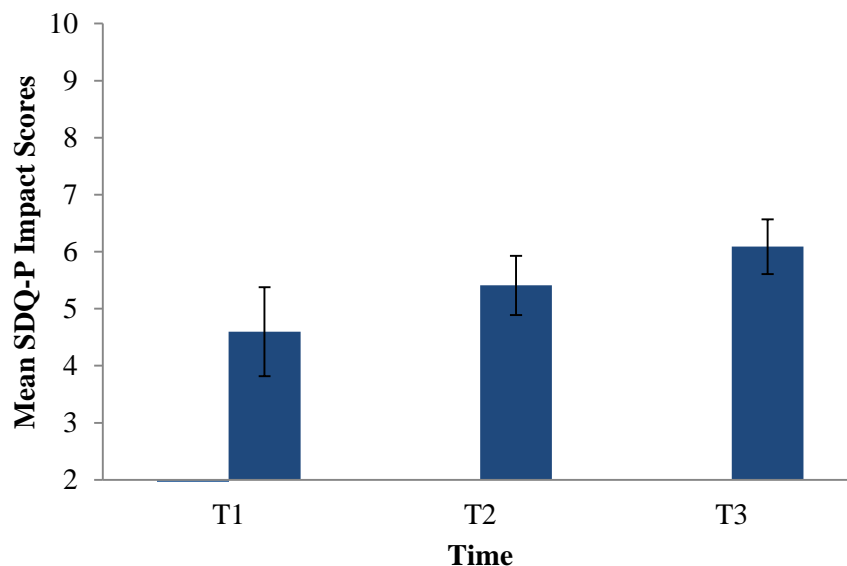


Figure 6.7: SDQ-P Scores by Age. Error bars represent standard error.

### *SDQ-P Impact Scale*

There was a significant main effect of Time on the SDQ-P impact scale,  $F(2,40) = 13.44$ ,  $p < .001$ , indicating a significant difference on the impact of negative attributes over time (T1:  $M = 4.6$ ,  $SD = 4.28$ , T2:  $M = 5.41$ ,  $SD = 2.19$ , T3:  $M = 6.09$ ,  $SD = 2.69$ ). This is further illustrated in Figure 6.8. There were no significant main effects of gender, age and no significant interactions of time and gender, and time and age on the SDQ-P impact scores ( $F < 1$  and  $p > .1$ ).



*Figure 6.8:* SDQ-P Impact Scores across Times. Levels of SDQ-P impact scores before (T1), after the programme (T2), and at three-month follow-up (T3). Error bars represent standard error.

Post hoc Comparisons (using Bonferroni correction (adjusted alpha level of 0.01 per test)) revealed a significant difference between T1 and T2,  $t(71) = 4.29$ ,  $p < .01$  (T1:  $M = 4.6$ ,  $SD = 4.28$ , T2:  $M = 5.41$ ,  $SD = 2.19$ ) and between T2 and T3, (T2:  $M = 5.41$ ,  $SD = 2.19$ ; T3:  $M = 6.09$ ,  $SD = 2.69$ ), indicating a significant difference on the

impact of negative attributes between pre intervention (T1) and post-intervention (T2) as well as between post-intervention (T2) and three month follow-up (T3).

#### *SDQ-T*

There were no significant differences in SDQ-T scores over time, gender, or age suggesting no difference over time, between boys and girls, as well as younger and older children in behavioural difficulties (negative attributes) as reported by teachers ( $F < 1$  and  $p > .1$ ).



### 6.5.3 Hypothesis 3: Analysis of Variances for EG vs. CG

Table 6.4: Mean and Standard Deviations for SA and ER Measures in EG and CG

	EG		CG	
	T1	T3	T1	T3
	M (SD)	M (SD)	M (SD)	M (SD)
<b>ERICA</b>	57.59 (8.83)	59.57 (8.81)	60.59 (6.69)	62 (7.65)
<b>PA</b>	41.15 (9.95)	42.90 (10.50)	46.88 (9.94)	46.93 (8.64)
<b>NA</b>	28.49 (10.42)	26.52 (10.01)	24.00 (9.09)	23.08 (7.94)
<b>SCAS</b>	22.46 (14.00)	20.42 (15.60)	17.29 (11.23)	15.88 (12.74)
<b>SPAI-C</b>	16.20 (10.34)	12.69 (8.83)	13.39 (7.94)	11.05 (8.15)
<b>SCAS-P</b>	20.55 (11.40)	15.50 (10.03)	16.19 (12.45)	14.18 (12.33)
<b>SDQ-P</b>	12.90 (8.67)	10.64 (7.58)	8.20 (5.14)	7.27 (4.44)
<b>SDQ-P Impact Scale</b>	4.60 (4.28)	6.09 (2.69)	1.27 (2.12)	3.69 (2.43)
<b>SDQ-T</b>	10.24 (7.35)	9.86 (7.36)	4.47 (4.54)	5.11 (4.50)
<b>SDQ-T Impact Scale</b>	2.63 (2.60)	4.18 (1.90)	1.11 (2.49)	3.40 (1.67)

*Note. ERICA=Emotion Regulation Index for Children and Adolescents; PANAS=Positive and Negative Affect Scale; SPAI-C=Social Phobia and Anxiety Inventory for Children; SCAS=The Spence Children's Anxiety Scale; SDQ=Strengths and Difficulties Questionnaire; Control group measures were taken at T1 and T3 only. Children Prevention Group across all measures: n = 85 at T1, n = 83 at T3; Children Control Group across all measures and both time points: n = 59; Parents Prevention Group across all measures: n = 83 at T1, n = 72 at T3; Parents Control Group across all measures: n = 59 at T1, n = 52 at T3; Teachers Prevention Group: n = 85 at T1 and n = 83 at T3; Teachers Control Group n = 19 across both time points.*

A Mixed 2x2 ANOVA with group (EG vs. CG) as the between-subjects variable and time (baseline vs. three-month follow-up) as the within-subjects variable was conducted to detect the effect of the ESST-C programme on emotion regulation (ERICA, PANAS), anxiety (SCAS, SCAS-P), social anxiety (SPAI-C), and emotional and behavioural difficulties (SDQ-P, SDQ-T). In addition Post-hoc analyses were conducted to investigate intra- and inter-group differences, where necessary, over time.

## *Changes in Psychological wellbeing after the implementation of the ESST-C programme*

*Main effects of time and condition on emotion regulation measures (ERICA, PANAS):*

### *ERICA*

There was a significant main effect of Time on ERICA scores,  $F(1,140) = 9.10$ ,  $p = .003$ ,  $\eta^2 = .06$ , indicating a significant difference on ERICA scores between pre intervention (T1) and three month follow-up (T3) (T1:  $M = 57.59$ ,  $SD = 8.83$ , T3:  $M = 59.57$ ,  $SD = 8.81$ ). The main effect of Group Condition was significant,  $F(1,140) = 4.96$ ,  $p = .027$ ,  $\eta^2 = .03$ , demonstrating a significant difference between experimental and control group on ERICA scores (CG:  $M = 61.30$ ,  $SD = 7.17$ , EG:  $M = 58.58$ ,  $SD = 8.82$ ). No significant group by time interaction was found ( $F(1,140) = 0.38$ ,  $p > .1$ ). These results are illustrated in Figure 6.9.

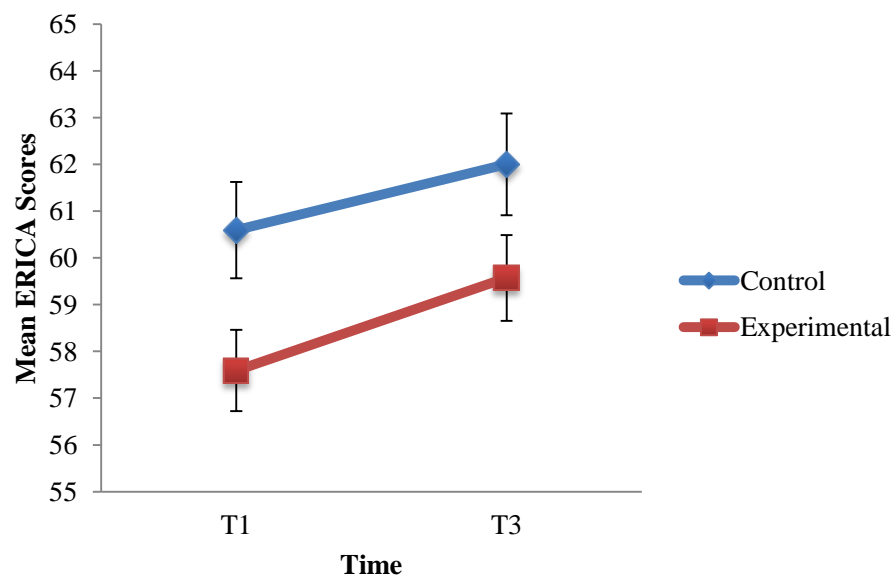
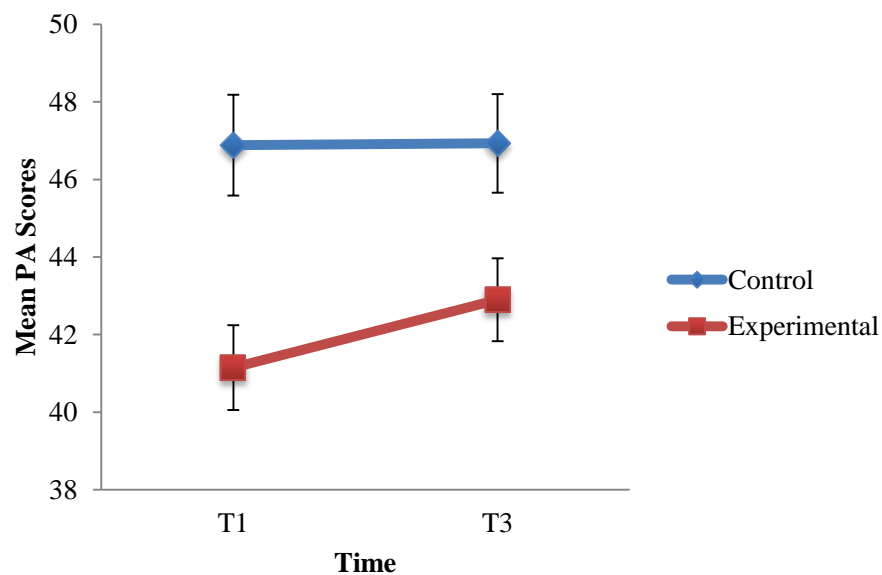


Figure 6.9: ERICA Scores across Time by Condition. Error bars represent standard error.

### *PANAS-Positive Affect Scale*

There was a significant main effect of Group Condition on Positive Affect scores,  $F(1,140) = 11.38, p = .001, \eta^2 = .08$ . Inspection of means indicated a difference between experimental and control group on ERICA scores (CG:  $M = 46.91, SD = 9.29$ ; EG:  $M = 42.03, SD = 10.23$ ). This is further demonstrated in Figure 6.10. No significant main effect of time ( $F(1,140) = 2.01, p > .1$ ) and no significant time by condition interaction was found ( $F(1,140) = 1.48, p > .1$ ).



*Figure 6.10: Positive Affect Scores across Time. Error bars represent standard error.*

### *PANAS-Negative Affect Scale*

The main effect of Time was significant in Negative Affect scores,  $F(1,140) = 5.49$ ,  $p = .021$ ,  $\eta^2 = .04$ , indicating a significant difference on NA scores between pre intervention (T1) and three month follow-up (T3) (T1:  $M = 28.49$ ,  $SD = 10.42$ , T3:  $M = 26.52$ ,  $SD = 10.01$ ). Moreover, there was a significant main effect of Group Condition,  $F(1,140) = 8.88$ ,  $p = .003$ ,  $\eta^2 = .06$ , demonstrating a significant difference between experimental and control group (CG:  $M = 23.54$ ,  $SD = 8.52$ ; EG:  $M = 27.51$ ,  $SD = 10.22$ ). No significant time by condition interaction was found ( $F(1,140) = 0.24$ ,  $p > .1$ ). These results are illustrated in Figure 6.11.

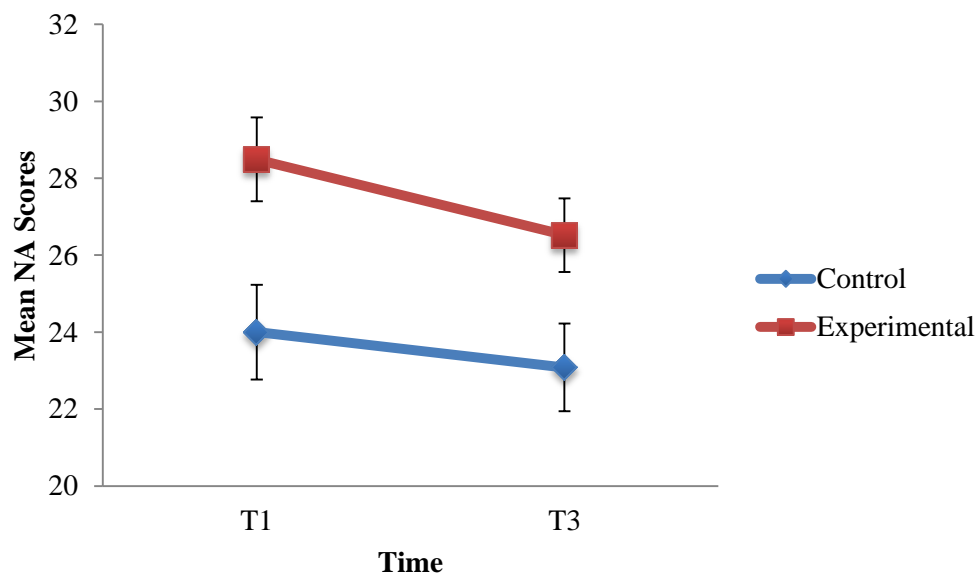
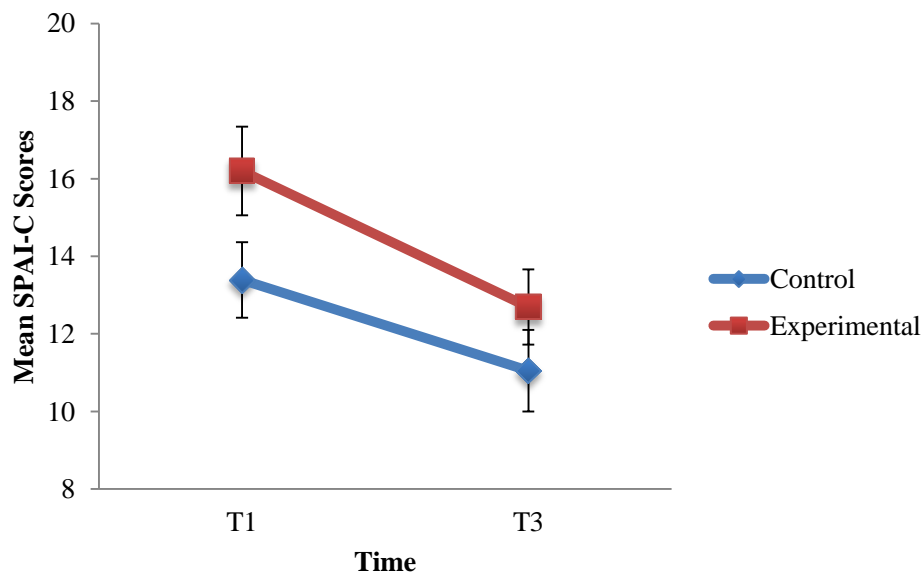


Figure 6.11: Negative Affect Scores across Time. Error bars represent standard error.

*Main effects of time and condition on social anxiety (SPAI-C):*

The main effect of Time was significant in SPAI-C scores,  $F(1,140) = 16.35$ ,  $p < .001$ ,  $\eta^2 = .11$ , indicating a significant change in SA scores from pre-intervention to three month follow-up (T1:  $M = 16.20$ ,  $SD = 10.34$ , T3:  $M = 12.69$ ,  $SD = 8.83$ ). No significant main effect of Group Condition ( $F(1,140) = 3.23$ ,  $p > 0.05$ ) and no significant time by condition interaction was found ( $F(1,140) = 1.06$ ,  $p > .1$ ). These results are presented in Figure 6.12.

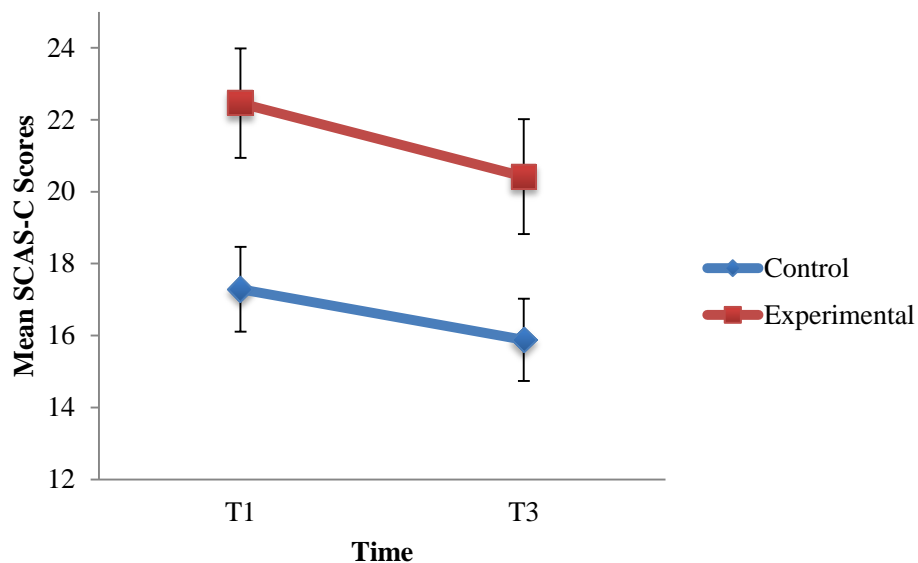


*Figure 6.12: SPAI-C across Time by Condition. Error bars represent standard error.*

*Main effects of time and condition on anxiety (SCAS-C, SCAS-P):*

#### *SCAS-C*

There was a significant main effect of Time on SCAS-C scores,  $F(1,140) = 5.6$ ,  $p = .019$ ,  $\eta^2 = .04$ , indicating a difference in SCAS-C scores over time (T1:  $M = 22.46$ ,  $SD = 14.00$ , T3:  $M = 20.42$ ,  $SD = 15.60$ ). Furthermore, a significant main effect of Group Condition was found,  $F(1,140) = 9.67$ ,  $p = .002$ ,  $\eta^2 = .07$ , suggesting a significant difference between experimental and control group (CG:  $M = 16.59$ ,  $SD = 11.99$ ; EG:  $M = 21.44$ ,  $SD = 14.80$ ). No significant time by condition interaction was found ( $F(1,140) = 1.06$ ,  $p > .1$ ). These results are illustrated in Figure 6.13.



*Figure 6.13: SCAS-C Scores across Time. Error bars represent standard error.*

### SCAS-P

There was a significant main effect of Time in SCAS-P scores,  $F(1,121) = 37.64$ ,  $p < .001$ ,  $\eta^2 = .24$ , indicating a significant change in anxiety scores as per parents' report over time (T1:  $M = 20.55$ ,  $SD = 11.40$ , T3:  $M = 15.50$ ,  $SD = 10.03$ ). In addition, there was a significant main effect of Group Condition in SCAS-P scores,  $F(1,121) = 5.8$ ,  $p = .018$ ,  $\eta^2 = .05$ , indicating a significant difference between EG and CG on anxiety scores as per parents' report (CG:  $M = 15.19$ ,  $SD = 12.39$ ; EG:  $M = 18.03$ ,  $SD = 10.72$ ). Lastly, a significant Time x Condition interaction was revealed,  $F(1,121) = 8.9$ ,  $p = .003$ ,  $\eta^2 = .07$ , indicating a significant difference between control and experimental group over time. The graph in Figure 6.14 goes in the direction of the hypothesis, suggesting a higher decrease in (S)A scores as per parents' report in the experimental as opposed to the control group.

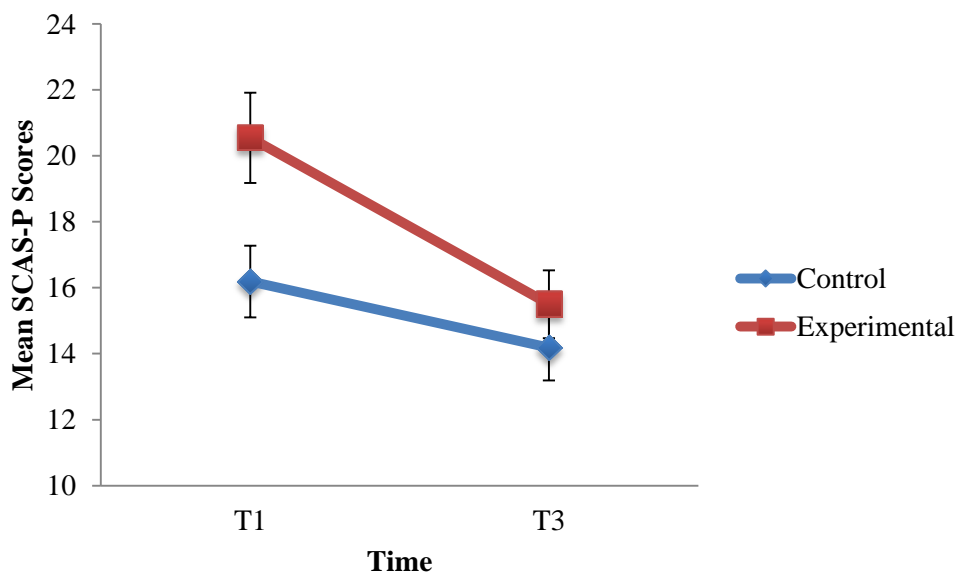


Figure 6.14: SCAS-P Scores across Time by Condition. Error bars represent standard error.

Using BC (adjusted alpha level of 0.0125 per test) post hoc comparisons were carried out to detect any differences in mean time scores between all pairs of conditions.

Independent samples t-test revealed a significant difference between experimental and control group at baseline,  $t(139.97) = 3.47$ ,  $p = .001$  (EG:  $M = 20.55$ ,  $SD = 11.40$ , CG:  $M = 16.19$ ,  $SD = 12.45$ ) and no significant difference at three month follow-up. This suggests a higher decrease of SCAS-P scores in the EG as opposed to the CG at three-month follow-up.

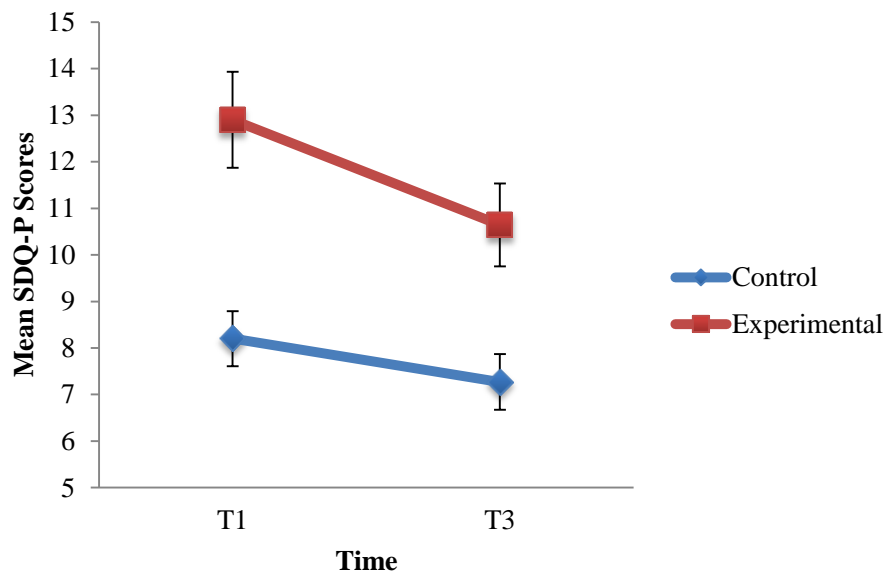
Post hoc Comparisons revealed a significant decrease of SCAS-P scores in the experimental group three months after the prevention had occurred,  $t(71) = 6.55$ ,  $p < .001$  (T1:  $M = 20.55$ ,  $SD = 11.40$  to T3:  $M = 15.50$ ,  $SD = 10.03$ ). In the control group no significant difference was detected over time, supporting the gains of the programme on anxiety levels as per parents' report.



*Main effects of time and condition on emotional and behavioural difficulties (SDQ-P, SDQ-T):*

#### *SDQ-P*

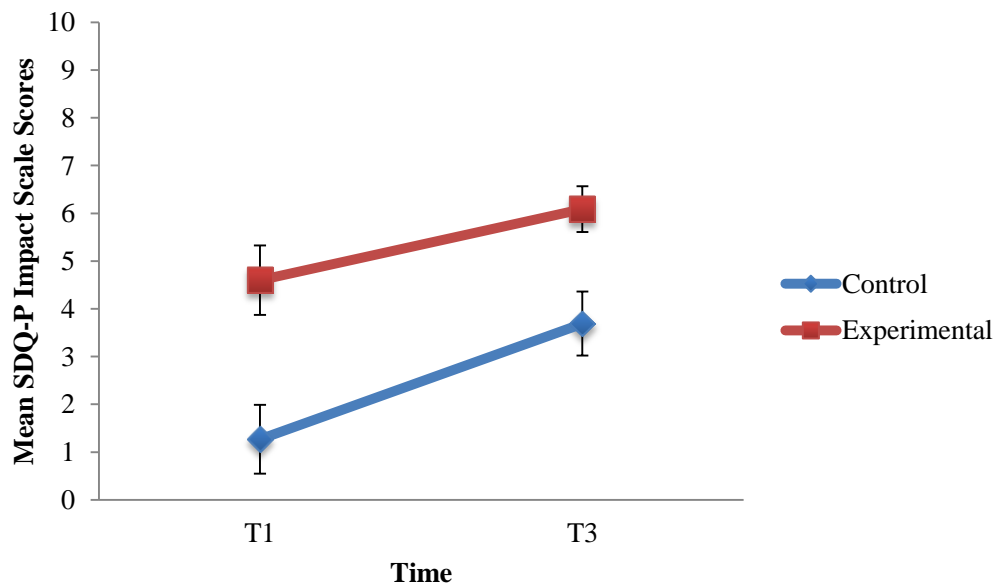
The main effect of Time was significant in SDQ-P scores,  $F(1,122) = 18.41$ ,  $p < .001$ ,  $\eta^2 = .13$ , indicating a significant difference in behavioural difficulties over time as per parents' report (T1:  $M = 12.90$ ,  $SD = 8.67$ , T3:  $M = 10.64$ ,  $SD = 7.58$ ). Moreover, there was a significant main effect of Group Condition,  $F(1,122) = 11.35$ ,  $p = .001$ ,  $\eta^2 = .09$ , demonstrating a significant difference between EG and CG on SDQ-P scores as per parents' report (CG:  $M = 7.74$ ,  $SD = 4.79$ ; EG:  $M = 16.77$ ,  $SD = 8.13$ ). No significant time by condition interaction was found ( $F(1,122) = 3.14$ ,  $p > 0.05$ ). These results are presented in Figure 6.15.



*Figure 6.15: SDQ-P Scores across Time by Condition. Error bars represent standard error.*

### *SDQ-P-Impact Scale*

There was a significant main effect of Group Condition on the impact scale of the SDQ-P,  $F(1,43) = 11.79$ ,  $p = .001$ ,  $\eta^2 = .22$ , indicating a significant difference between EG and CG on the impact scale of the SDQ-P scores as per parents' report (CG:  $M = 2.48$ ,  $SD = 2.28$ ; EG:  $M = 5.35$ ,  $SD = 3.49$ ). In addition, there was a significant Time x Condition interaction,  $F(1,43) = 4.17$ ,  $p = .049$ ,  $\eta^2 = .09$ , indicating a significant difference between control and experimental group on the impact scores of the SDQ-P across time (CG T1:  $M = 1.27$ ,  $SD = 2.12$ , T3:  $M = 3.69$ ,  $SD = 2.43$ ; EG T1:  $M = 4.60$ ,  $SD = 4.28$ , T3:  $M = 6.09$ ,  $SD = 2.69$ ). The graph in Figure 6.16 depicts a larger increase of the impact of behavioural difficulties in the control group as opposed to the experimental group.



*Figure 6.16:* SDQ-P Impact Scores across Time by Condition. Error bars represent standard error.

Using BC (adjusted alpha level of 0.0125 per test) post hoc comparisons were carried out to detect any differences in mean time scores between all pairs of conditions.

Independent samples t-test revealed a significant difference between experimental and control group at baseline,  $t(125.5) = 6.08, p < .001$  (EG:  $M = 4.60, SD = 4.28$ , CG:  $M = 1.27, SD = 2.12$ ) and a significant difference at three month follow-up,  $t(44) = 2.8, p = .008$  with EG children reporting a higher impact on behavioural difficulties as opposed to CG children (EG:  $M = 6.09, SD = 2.69$ , CG:  $M = 3.69, SD = 2.43$ ).

Post hoc Comparisons did not reveal significant differences in the experimental or control group over time ( $p > .01$ ).

### *SDQ-T*

There was a significant main effect of Group Condition,  $F(1,100) = 11.4, p = .001, \eta^2 = .102$ , indicating a significant difference between EG and CG on the SDQ-T measure (CG:  $M = 6.29, SD = 4.52$ ; EG:  $M = 10.05, SD = 7.36$ ). No significant main effect of time ( $F(1,100) = 0.10, p > .1$ ) and no significant time by condition interaction was found ( $F(1,100) = 3.84, p > .1$ ). These results are further illustrated in Figure 6.17.

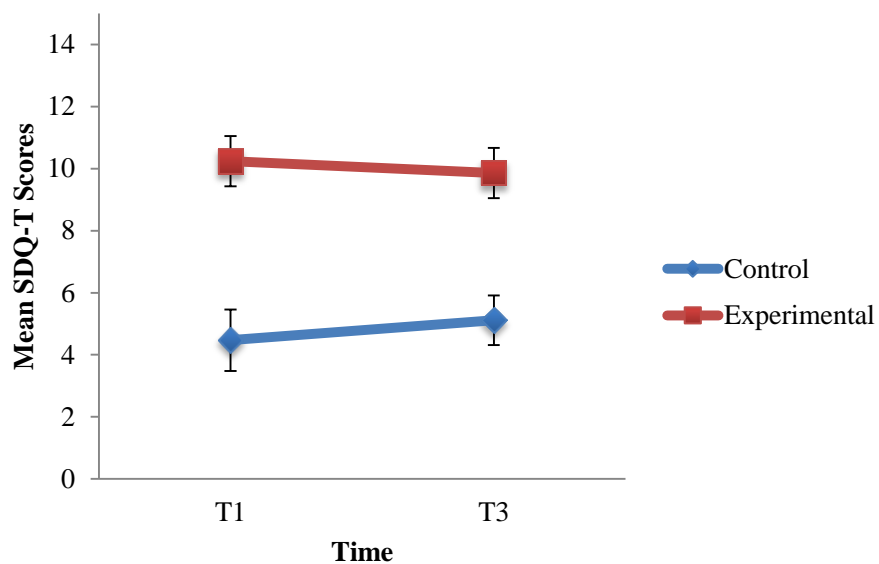


Figure 6.17: SDQ-T across Time by Condition. Error bars represent standard error.

#### *SDQ-T-Impact Scale*

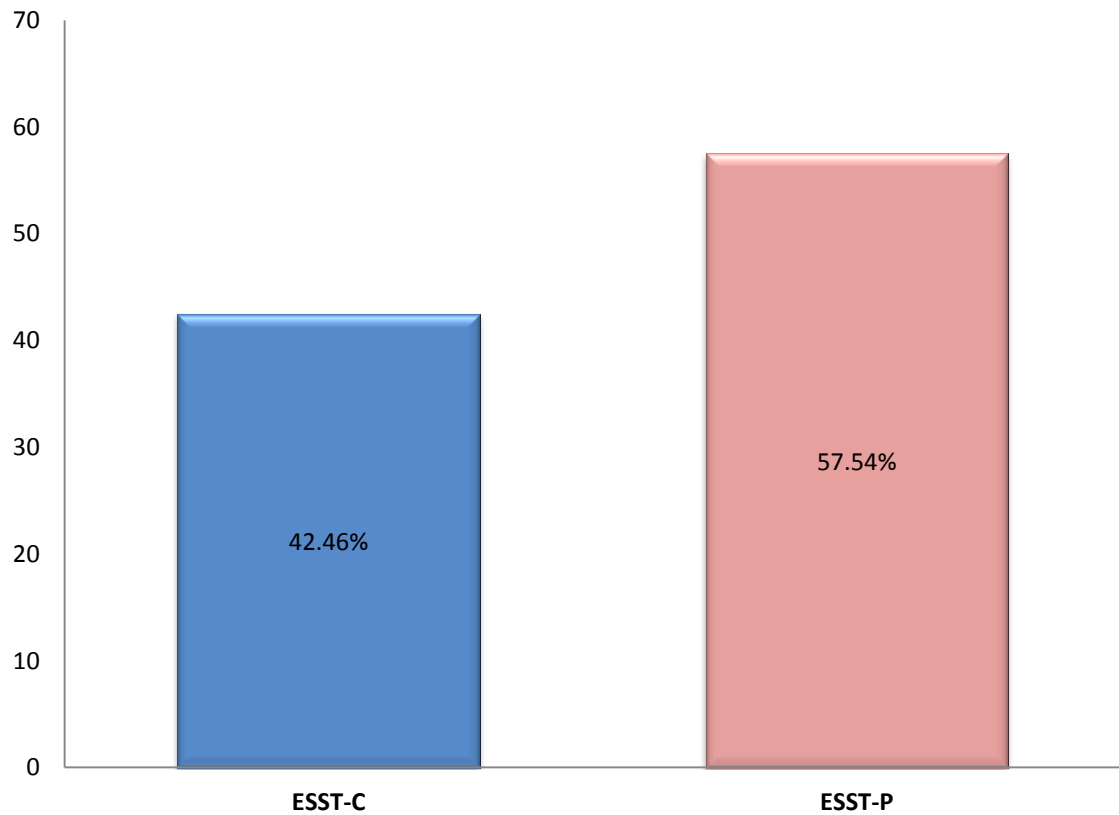
There were no significant main effects or interactions detected over time on the SDQ-T Impact Scales scores ( $F < 1$  and  $p > .1$ ).

#### *6.5.4 Summary of Key Findings*

The hypotheses were supported and rejected as follows:

- (1) The ESST-C significantly increased levels of ER and decreased levels of SA and behavioural difficulties over time in the experimental group, supporting the first hypothesis.
- (2) Girls compared to boys, and younger compared to older children, did not benefit more from the ESST-C programme, except on the ERICA (ER measure), where boys significantly increased on levels of ER, and on the SDQ-P (behavioural difficulties measure, parents' report), where younger children generally scored lower compared to older children, indicating boys and younger children to have benefitted more on ERICA and behavioural difficulties (as per parents' report). Thus, overall, rejecting the second hypothesis.
- (3) In comparison to children in the CG, children who participated in the ESST-C programme did not report significantly lower levels of SA at three-month follow-up and significantly higher levels of ER than those in the CG, except on the SCAS-P, overall, rejecting the third hypothesis.

### 6.5.5 Parents' & Children's Satisfaction



*Figure 6.18:* Parents' and Children's Satisfaction. The graph illustrates the overall satisfaction rate of 77 children (ECST-C) and 53 Parents (ECST-P) on the ESST-C programme.

## *6.6 Discussion*

The main objective of the current study was to examine the efficacy of a newly developed CBT-based programme including ER strategies focussed on the reduction of SA and behavioural difficulties and the enhancement of ER levels in children. To our knowledge the ESST-C is the first programme that combined these successful components in a preventative, brief, and accessible approach. Overall, the findings showed that the ESST-C had a positive impact on children's anxiety levels as reported by the children's parents. Furthermore, the significant relationship between SA and ER was presented in the correlation analyses. These indicated that children with lower levels of ER demonstrated higher levels of SA and behavioural difficulties and vice versa, as reported by parents and teachers also. The findings further emphasise the importance of ER in the prevention and intervention of SAD in children.

### *6.6.1 Primary Findings*

In support of the first hypothesis concerning the effectivity of the ESST-C, the mixed 2x2x3 ANOVA with gender (male vs. female) and age (high vs. low) as the between-subjects variable and time (baseline vs. post-intervention vs. three-month follow-up) as the within-subjects variable, revealed a significant main effect of time on all measures, except the SCAS-C (anxiety scale for children), the PANAS (Positive & Negative Affect Scales), and the SDQ-T (behavioural difficulties measure teacher's report). In other words, children who went through the ESST-C increased in their levels of ER and showed decreased levels of SA and behavioural difficulties over time as presented by the significant main effects of time on ERICA (ER measure), SPAI-C (SA measure for children), SCAS-P (anxiety measure, parents' report), SDQ-P and SDQ-P impact scale (behavioural

difficulties, parents' report). The post-hoc comparisons revealed a significant increase of ER levels (as measured by ERICA) from baseline (T1) to three-month follow-up (T3), and the significant interaction between time x gender, followed by post-hoc comparison, demonstrated a significant increase of ER from T1 to T2 and T1 to T3 in boys. The post-hoc comparisons for SA (as measured by SPAI-C), anxiety (as measured by SCAS-P, parents' report), and behavioural difficulties (as measured by SDQ-P, parents' report) indicated a significant decrease of SA, anxiety levels in general, and behavioural difficulties from T1 to T2 and T1 to T3. However, no causal conclusions can be made as to whether these enhancements are due to the ESST-C or simply natural development. This is further discussed in 6.6.3 and 6.6.5.

Regarding the second hypothesis, the main effect of Age on the Positive Affect scale of the PANAS as well as on the SDQ-P (behavioural difficulties, parents' report) suggested that there was a difference between younger and older children on PA and SDQ-P scores. As, however, no significant main effects or significant interactions were demonstrated on any other ER and SA measures with regard to age or gender (except on ERICA), the second hypothesis stating that girls compared to boys and younger compared to older children would benefit more from the ESST-C, was rejected. This is further discussed in 6.6.2.

In support of the third hypothesis, the mixed 2x2 ANOVA with group (EG vs. CG) as the between-subjects variable and time (baseline vs. three-month follow-up) as the within-subjects variable, revealed significant interactions between time and condition on the SCAS-P (anxiety measure parents' report) and SDQ-P impact scale (behavioural difficulties measure, parents' report). As, however, no further significant interactions were found, the hypothesis that



children who participate in the ESST-C programme will report lower levels of SA at three month- follow up and higher levels of ER than those in the CG, was rejected. The significant main effects of time and/or condition on all measures showed, overall, significant differences between pre-intervention and three-month follow up, and generally higher levels of SA, behavioural difficulties, and ER in children in the experimental group, which could have affected these results.

In some cases children in the control group seemed to have improved over time due to natural development (e.g., ERICA, SCAS-C, SPAI-C, SDQ-P), this could have also been due to the degree of intervention psychological measures generally have (Bender et al., 2012). According to Bender and colleagues (2012) the exposure to psychological measures can be intervening in itself and thus have an impact on the participant. In addition, the unequal numbers in both groups as well as the generally higher levels of EG children on (S)A and behavioural difficulties, and lower levels on ER could have influenced these results. Post-hoc comparisons on the SCAS-P (anxiety measure, parents' report), however, revealed a significant difference at baseline between experimental and control group, which was no longer present at three-month follow up, suggesting a decrease of anxiety levels (as per parents' report) in the experimental group. In addition, post-hoc comparisons further revealed a significant improvement in the EG on the SCAS-P that was not present in the CG. Nonetheless, the findings are, overall, not in support of the third hypothesis concerning the effectivity of the ESST-C between control and experimental group.

The importance of ER enhancement skills was however highlighted by the significant correlations. For example, the significant negative correlations between SA (SPAI-C, SCASSOC) and ER (ERICA) suggested higher levels of SA to be associated with lower levels of ER. Furthermore, the significant positive correlations between SA (SPAI-C, SCASSOC) and Negative Affect (NA of the PANAS) indicated higher levels of SA to be associated with higher levels of negative affect. With regard to anxiety in general (SCAS-C as measured by children, SCAS-P as measured by parents) findings showed a strong negative correlation with ER (as measured by ERICA), indicating higher levels of anxiety to be associated with lower levels of ER. Moreover, statistically significant positive correlations were found between anxiety (SCAS-C, SCAS-P) and Negative Affect (NA of the PANAS), suggesting higher levels of anxiety to be associated with higher levels of negative affect. This was further supported by a strong negative relationship between SCAS-P and Positive Affect scores (PA of the PANAS) indicating higher levels of anxiety (as measured per parents' report) to be linked to lower levels of positive affect.

Lastly, the significant negative correlations between behavioural difficulties (SDQ-P, as measured by parents, and SDQ-T, as measured by teachers) and ER (as measured by ERICA) and Positive Affect (PA scale of the PANAS) suggested that high levels of behavioural difficulties are linked to low ER and Positive Affect. This is in accordance with a further statistically significant and strong positive relationship between behavioural difficulties (SDQ-P, SDQ-T) and Negative Affect scores indicating higher levels of behavioural difficulties (as measured per parents' and teacher's report) to be associated with higher levels of negative affect. This further demonstrates the

link between ER and SA, ER and anxiety, as well as ER and behavioural difficulties, supporting the notion that including ER components in prevention programmes may be advantageous.

In the light of the above it could be argued that the results of the current study fill the dearth in the literature outlined previously. The results emphasise the importance of combining ER with CBT which could lead to increased levels of ER, and in turn promote lower levels of SA and, thus, an increase in the quality of a child's life. This is in line with previous findings suggesting that the increase of ER and decreased levels of SAD could have an impact on the biased beliefs of individuals diagnosed with SAD (Mahone et al., 1993). Similarly, past studies have demonstrated that individuals with SAD tend to apply positive suppression more frequently. This can, in turn, lead to slightly fewer positive social events and to less intense positive emotions (Farmer & Kashdan, 2012). Suppression, therefore, increases self-monitoring and thereby simultaneously intensifies an individual's attention towards possible social evaluative threats in participants with high levels of SAD (Bögels & Mansell, 2004). However, while individuals that worry about displaying anxiety may find it easy to maintain negative emotions, the choice to suppress positive emotions may be more challenging. As a result, the suppression of positive emotion may overstretch self-regulatory resources, particularly those that are needed for successful social interactions (English & John, 2013; Muraven & Baumeister, 2000).

In sum, people high in SAD seem to be less able to apply adaptive ER strategies to minimise their evaluation concerns. This may also be the cause of increased anxiety and contribute to the maintenance of SAD. The expression of positive emotions is vital in an individual's ability to experience positive

occurrences (Fredrickson, 1998), as well as in the capacity to develop close affiliations (Halberstadt et al., 2001). Existing literature has shown that individuals who are more expressive of positive emotions are usually also more often described as thoughtful, friendly, and sincere (Otta et al., 1994). Thus, individuals with SAD, who suppress positive emotions, may intensify their anxiety of being negatively perceived by others (Clark & Wells 1995; Rapee & Heimberg 1997). Consequently, the enhancement of social and emotional skills seems crucial in the prevention and intervention of SAD and has contributed to the positive results of the ESST-C.

#### *6.6.2 Unexpected Findings*

In contrast to previous findings the current study did not find any significant differences over time in younger (8-9) and older (10-11) children (except on the Positive Affect scale of the PANAS, and the SDQ-P). This indicates that, overall, the programme benefited the age group of 8-11 equally on ER, behavioural difficulties, and anxiety measure (as per parents' and children's reports). This unexpected finding, considering that previous literature suggested improvements in older children more than in younger children, may be due to the much smaller sample size utilised in the current study, among other factors. The study by Essau and colleagues (2012), for example, revealed symptom improvement of SAD between 9-11 years employing a sample size of 556 children. Furthermore, the authors revealed that girls were more affected by anxiety symptoms than boys, which, again, is in accordance with other past findings (Cohen et al., 1993, cited in Compton et al., 2000). The only significant interaction between time x gender in the present study was on the ERICA, and implies a higher increase of ER in boys as opposed to girls.

Furthermore, the unexpected, non-significant time x condition interactions on ER, (S)A, and behavioural difficulties measures, could have been due to the significant differences between EG and CG on all measures but the SPAI-C. The experimental group revealed generally higher levels of Negative Affect, SCAS (anxiety, children's and parents' report), and SDQ (behavioural difficulties, teacher's and parents' report) and lower scores of ERICA (emotion regulation) and PA (positive affect), which could have contributed to the non-significant findings. Nevertheless, the natural developments of the control group, as well as the unexpected outcomes of the current measures, call for future refinements in this field of research, to achieve more conclusive findings.

### *6.6.3 Limitations*

Despite the novelty of the current study, the findings should be interpreted within the context of its limitations. First, the fact that the present study was carried out in the south west of London only, may be viewed as a limitation as it restricts the general application of results, considering that it is not representative of other areas in the UK. Secondly, although significant improvements in SA and ER were observed in the experimental group, it is not conclusive that this is due to the programme, as the significant differences in mean times scores could also be due to natural development. In addition, the natural development of the control group (CG) and the non-significant time x condition interactions, make generalisation difficult. However, the results of the present study are not discrepant from those of other published studies. Furthermore, the non-significant time by condition interactions may have been due to significant differences between EG and CG on all measures but SPAI-C, generally,

indicating lower levels of ER and higher levels of anxiety in the experimental group as opposed to the control group.

Nonetheless, a few more caveats to the interpretation of the findings remain. The ER measures were rather generic and did not specify particular strategies. As such, children reported on their levels of ER in general, thereby indicating the ability to apply regulatory strategies. Thus, in order to comprehend the full impact of ER in SAD, it may be expedient to assess deliberate as well as automatic processes that affect emotional experiences (Forgas, 1995). In addition, more situation- and ER-specific assessments in future studies could clarify the success and impact of specific strategies further. Moreover, forthcoming research may contribute to existing findings by investigating other important components in intervention and prevention programmes that may be more beneficial, for example, exploring the relationship between parents' and children's levels of SAD and ER. Finally, findings are limited to the use of self-report measures, which are known for low levels of participant self-awareness, response biases, and social desirability limitations (Paulhus, 1991).

Despite these limitations as well as the strengths of self-report measures, its use in ER in youth is difficult, due to the problems inherent in unravelling early activation of emotions and the challenges in reporting one's usual responses to emotional experiences (Cole et al., 2004). The tendency is to remember the most recent experience and link it with the most recent emotion experienced (Fredrickson, 2000; Stone et al., 1998). This could have an impact on the reports of trait ER. The problem could be avoided by using other more experimental measures to assess ER (Chaplin, 2006; Cole, Zahn-Waxler, Fox, Usher, & Welsh, 1996). However, such measures tend to be impracticable for

use with large community samples like the current study. Additionally, recent research supports reputable compatibility between self-report and physiological measures of ER among youth (Hessler & Katz, 2007). A number of previous, successful studies have relied on self-report measures of ER when examining ER and youth psychopathology (Sim & Zeman, 2005; Southam-Gerow & Kendall, 2000; Zeman et al., 2002). Moreover, this method is known to be a fast process of data collection that is not only relatively inexpensive but also enables the prompt evaluation of emotions, which are evanescent in nature (Aldao et al., 2010; Spokas et al., 2009).

A further limitation of the current study is that no booster sessions were provided, which may explain non-significant findings and similarities to the CG. Future programmes should offer booster sessions, a few months after the initial programme, to emphasise the skills or techniques that were taught and thus, maintain positive outcomes over an extended time. Additionally, an increase of sessions may produce more lasting change (Spence & Shortt, 2007). Furthermore, some discrepancies may be due to the lower number of children in the CG. The high dropout rate of participants from the CG could be explained by the fact that no immediate incentive was provided for that group. The employment of a wait-list condition to undertake the programme may eliminate such issues. This may further help to increase/maintain the sample size, thereby strengthening the general application of the findings.

#### *6.6.4 Strengths*

Considering the nature and significance of the findings that have been addressed in this discussion, it is essential to reflect on the practical benefits the ESST-C had on the participants, and the strengths of the current study, despite the

limitations and unexpected findings discussed. The effectiveness of the programme was measured empirically as well as objectively, which in line with the principles of active practice is a direct goal of research. The improvements that were indicated in children's levels of SA, behavioural difficulties, and ER are of high importance, though in comparison to the CG these findings were not fully supported. The current study aims to encourage future research directed at finding ways of reducing the development of SAD. Consequently, the findings of this study are original, in terms of important components that should be considered and researched further in prevention programmes for SAD. They are relevant to current research concerning the rising numbers of young individuals that are diagnosed with SAD (Beidel et al., 2000; Hitchcock et al., 2009; Rapee & Spence, 2004) and the necessity to explore the inclusion of ER in treatment (Gross et al., 2006; Gross & Muñoz, 1995).

The present early intervention programme is novel, in that it takes a multi-dimensional approach. Children are provided with a variety of social and emotional skills to enable them to create an individualised and effective tool kit for dealing with challenging situations. Building on a sound theoretical basis, grounded in successful CBT principles (e.g., Barrett & Turner, 2001; Essau et al., 2012; Shortt et al., 2001), the principles and process model of ER (Gross, 1998b) to address the concerns of theoretical nature as well as the findings of Study One, the current research endeavours to tie together theory and practice. This is by enhancing children's awareness and understanding, which is essential for the development of the requisite skills that provide interpersonal, academic, and health enhancements that allow individuals to have a more enriched life experience (Berking & von Känel, 2007; Denham et al., 2002a; Leerkes et al.,



2008; Ollendick et al., 2010; Mennin et al., 2009). Accordingly, the newly developed ESST-C programme for children (Essau et al., 2011) is designed for a young community sample. Moreover, the current prevention offers a small dose of each training component in a preventive fashion in pursuance of providing children with coping skills for future socially and/or emotionally challenging situations. Notwithstanding the similarities between the ESST-C and conventional CBT interventions, the ESST-C combines various techniques that are found significant in many different training programmes. This is in accordance with Smyth and Arigo (2009), who reinforced the combination of CBT and ER techniques to lead to greatest benefits, when compared to interventions that engaged either set of techniques independently.

In the current study children were presented with the opportunity to individualise their experience of the training programme by adopting the techniques that were most useful, based on their personality, the situation and their aims (Kotsou et al., 2011; Egloff, Schmukle, Burns, & Schwerdtfeger, 2006). In addition, the inclusion of ER strategies increased the ecological validity of the study, as it enabled the theoretical and practical focus on flexibility in children. The improved understanding of physiological and psychological sensations in children can enhance their flexibility to face the numerous challenges in day-to-day life, which they can then manage in adaptive ways (Cheng, 2001). High emotional competence and psychological flexibility are a fundamental component of adaptive human functioning and a crucial asset for successful adaptation (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004). They are taught in most successful psychological interventions, even when they are not named as a specific intervention goal (Kashdan & Rottenberg,

2010). Lastly, a school-based intervention is not only more accessible, but also more acceptable for parents due to the reduced stigmatisation that goes with this. The social- and emotion regulation skills incorporated in the ESST-C, could benefit all children in their social and own individual development, thereby strengthening and widening the benefits of this programme.

The main strength of the current study is, therefore, that it addressed a number of present concerns and limitations in the field of SAD in children. The effectivity of the ESST-C could also be supported by the fact that it was not delivered by only one trainer, but by six facilitators in total, supporting the notion that the programme in itself was likely to be beneficial in the reduction of SA and enhancement of ER levels rather than due to the facilitator of the programme. Moreover, it included a diverse sample, incorporating a significant age group, concerning the developments that children go through, particularly between the ages of 8 years and onward. In addition, the various measures and the inclusion of ER strategies differentiate the current study from existing ones in an advantageous way. Furthermore, the follow-up allowed the assessment of programme benefits over some time.

A longitudinal design enables the observation of any changes in the various parameters after three months and despite the brevity of the programmes, similar time frames have been utilised effectively in interventions including CBT (e.g., Burton, Schmertz, Price, Masuda, & Anderson, 2012). The psycho-educational approach and involvement of school staff supports the accessibility of programmes. This can reduce the number of children at risk of SAD and enhance vital ER skills, beneficial to all children. Lastly, the inclusion of parents

seems an important feature to increase the transfer and application of skills to the child's home environment (e.g., Crosby et al., 2012, Hane et al., 2008).

#### *6.6.5 Interpretation of Findings and Future Directions*

The findings of the present study, generally, support the notion that the combination of the CBT and ER principles, upon which the programme has been based, contributes to the possible prevention of SAD. This is in line with previous research supporting the benefits of this combination (e.g., Kley et al., 2012; Smyth & Arigo, 2009). Implementing CBT techniques that are aimed at interpretation biases and teaching cognitive adaptation strategies (Essau et al., 2012; Hofmann, 1997; Turner et al., 1994) as well as social and emotional skill enhancements strategies, provide children with necessary abilities to reduce the risk of developing SAD (Kashdan et al., 2011). The correlational findings further highlighted the significant relationship between SA and ER in children. These findings are in line with previous literature suggesting that SAD and ER are related (e.g., Erwin et al., 2003; Kashdan & Collins, 2010; Spokas et al., 2009; Turk et al., 2005; Werner & Gross, 2010). Thus, the importance of including adaptive ER strategies in the treatment and prevention of SAD is highlighted.

The components of Gross's process model emphasise the importance of timing when it comes to applying regulatory strategies. As discussed above, antecedent strategies, such as attention deployment, cognitive change, situation selection, and situation modification (Beck & Dozios, 2011; Gross, 1998b; Hofmann, 2000) are employed early in the emotion-generative process. Furthermore, these strategies are more psychologically adaptive in contrast to approaches that arise later in the process, known as response-focused strategies (Gross, 2007) and have so far shown to be of advantage. In line with this, the

combination of the components applied in the current study is found to be useful in many ways and should be employed in future treatment and intervention programmes. The notion that suppression (response-focused strategy) has more negative health consequences and is less effective as opposed to antecedent-focused strategies such as cognitive reappraisal (Gross & John, 2003) is widely supported (Hofmann, Friese, & Strack, 2009; Gross & John, 2003; Kashdan & Steger, 2006). Hence, the ESST-C programme utilised within this study focused primarily on teaching children emotion regulation and social skills based on CBT principles and antecedent-focused strategies such as reappraisal (John & Gross, 2004).

Moreover, the ESST-C programme sought to educate children about thoughts, feelings and problem solving skills, while also teaching diaphragmatic breathing and PMR in order to provide participants with positive response focused strategies in addition to the wide skills that were offered. The diversity of various strategies that were taught, in order to provide children with different tools suitable to address feared social situations, is in line with previous research that suggests intervention programmes to employ a multidimensional approach (Kley et al., 2012; Hannesdottir & Ollendick, 2007; Suveg et al., 2007). This is understood to be more effective than teaching one strategy that may then be used inflexibly (Seligman, Steen, Park, & Peterson, 2005). By teaching children a variety of concepts and strategies children are enabled to choose the most effective strategy and minimise their anxiety about feared situations (Essau et al., 2012; Shortt et al., 2001; Sin & Lyubomirsky, 2009).

In addition, despite the combination of important components applied in the ESST-C programme, future research should try and focus on different ER strategies such as attention selection (Gross et al., 2006) in more detail. Moreover, psychological flexibility and the impact this has on an individual's wellbeing should be investigated in greater depth, especially in children (Bonanno et al., 2004). Finally, having homogenous age groups may enhance children's interest and motivation as interactions might be more likely to occur outside of the sessions and the topics discussed in the programme can be linked to that particular age group more easily. In mixed age groups, younger children may find it more challenging to grasp certain concepts at the same speed as their older peers, and perhaps feel intimidated by the older children (e.g., Wood et al., 2003). As a result, the implementation of the programme requires consideration of the ages of the participants, although the ESST-C is applicable for a wider age range.

In terms of the participants' satisfaction of the ESST-C, both children and their parents evaluated the programme as very positive (see Figure 6.18). While children reported increased coping skills and the recommendation of the programme to other children, parents also provided extremely favourable feedback with regard to the ESST-C. Parents and school SENCO reported increased competences in the children who participated in the programme and were very much in favour of its implementation. Future work, however, should include the direct assessment and evaluation of teacher satisfaction. In addition, the utilisation of equal control and experimental groups from different economic and cultural backgrounds could reduce many existing limitations of

generalizability (Bögels et al., 2010; Nelis, Quoidbach, Mikolajczak, & Hansenne, 2009).

#### *6.6.6 Conclusion and Research Implications*

In sum, children in the EG presented an increase of ER levels and decrease of (S)A and behavioural difficulties levels over time. Therefore, no causal conclusion can be made that these benefits are due to the programme or natural development. With regard to differences between control and experimental group, only the SCAS-P supported the notion that the programme led to significant improvements in levels of anxiety (as measured by the children's parents) at three-month follow-up in EG as opposed to the CG. Moreover, there were significant correlations between ER (as measured by the positive affect scale and ERICA) and SA, SA and behavioural difficulties, as well as ER and behavioural difficulties, supporting the notion that high levels of SA are associated with low levels of ER and high levels of behavioural difficulties, while increased levels of ER are linked to low SA and behavioural difficulties. Based on the current findings, future studies should consider the inclusion of particular components in school settings. This has been demonstrated to be a valuable practice for the reduction of the development and maintenance of psychological disorders such as SAD from an early age.

Overall, the focuses on teaching and applying skills as well as the active teaching methodologies of the ESST-C, its brevity, accessibility, and preventative nature could contribute to the concept and aim of the existing PSHE education, though the unexpected findings, particularly, in regard to non-significant time x condition interactions call for further research and refinements.

Future research should therefore test the current programme with children that have similar levels of ER and (S)A to begin with and aim to ensure more equal participant numbers in each condition. The provision of a wait-list condition could possibly reduce dropout rates and enable more equal (sized) samples from the start. Hence, further examination is warranted, in order to increase the benefits of prevention programmes, such as the ESST-C, in the future. Moreover, the inclusion of qualitative assessments and analysis, as well as parents' experiences of their children, and children's own experiences may enhance our current understanding of how challenging situations are perceived, which in turn could contribute to the refinement of programmes, such as the ESST-C.

## Chapter Seven: Study Three

### **An Exploratory Qualitative Study of Children's and their Mothers' Reflections on Challenging Situations**

#### *7.1 Introduction*

In this chapter the aim is to present a qualitative study exploring participant children and their parents' reflection on socially and emotionally challenging situations. This was conducted to address some of the issues identified in the previous studies that will be outlined further in the section below. Interpretative Phenomenological Analysis was the chosen methodology to map out key themes in the data set generated in interviews with nine 7-12 year olds, and their respective mothers (see 7.3.2).

#### *7.2 Interpretative Phenomenological Analysis*

Consistent with Miles and Huberman (1994), a qualitative approach enables the attainment of rich descriptive and interpretative data that are rooted in a real context. Qualitative research comprises various types, one of them being phenomenology from which Interpretative Phenomenological Analysis (IPA) stems (Giorgi, 1995). The nature of phenomenology is to study the perceptions and experiences of participants. According to Fade (2004; p. 648), "The researcher's beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals. Reflexivity is viewed as an optional tool, enabling the researcher to formally acknowledge his or her interpretative role, rather than as an essential technique for removing bias". This development in phenomenological research is referred to as IPA. The following will introduce the fundamental concepts of IPA and the rationale for using this approach in the current thesis.



IPA was developed by Jonathan Smith (Smith, Harré, & Van Langenhove, 1995) and offers accurate explorations of idiographic, subjective experiences, and social cognitions. Thus, it has been widely used in psychology (e.g., Thompson, Kent, & Smith, 2002; Clare, 2003; Eatough, & Smith, 2006; Hedman, Ström, Stünkel, & Mörtberg, 2013; Larkin, Eatough, & Osborne, 2011; McManus et al., 2010) including health psychology (e.g., Fade, 2004; Mulveen & Hepworth, 2006), counselling psychology (Friedman & Friedlander, 2005; Wertz, 2005), and family studies (Peterson & Jenni, 2003). The theoretical underpinnings of IPA stem from the phenomenology that originated from Husserl's attempts to construct a philosophical science of consciousness. The theory posits that the meaning an individual gives to an event is vital, though only accessible through an interpretative process. On that account, IPA recognises the interpretative engagement of the researcher with the participant's text, which, in contrast to other methods (e.g., discourse analysis, Potter, 1996), adopts an epistemological position. It thereby facilitates access to the individual's cognitive inner world through a careful and explicit interpretative methodology. In other words, while discourse analysis explores the role of language used by participants to describe their experience, IPA examines the way in which individuals assign meaning to their experiences (Smith, Jarman, & Osborne, 1999). By definition, researchers propose IPA to be most suitable to investigations that aim to combine the findings with psychosocial theories that inform current thinking among healthcare professions (Smith, 1996; Willig, 2001; Smith, 2004).

Considering that IPA works with texts, such as interview transcriptions, it emphasises the importance of language, which is used to reveal the actual

experience. It suggests that language provides participants with the required tool to capture and communicate their experience and is therefore, dependent on the representational validity of the language used (Biggerstaff, & Thompson, 2008). Others have argued, however, that language is not appropriate to describe but rather to construct experience, and so it is unable to ‘give expression to experience’ (e.g., Willig, 2001). Moreover, Smith (1996) argues that IPA focuses on cognition based on understanding what an individual thinks or believes about a certain topic. This, in turn, may be incompatible with phenomenology and raises some confusion in the underpinnings of IPA. Nonetheless, considering that the IPA approach combines a rich description of a phenomenological ‘core’ with the more theoretical development of an interpretative account, it enables the in-depth and reliable analysis of an individual’s experience. IPA has indeed presented various successful analyses in the past, which were contributing to the field of research in many different areas (e.g., Fade, 2004; Peterson & Jenni, 2003; Wertz, 2005). According to Fade (2004) IPA pursues the perspective of an insider on their lived experiences, whilst also identifying the researcher’s personal beliefs, and endorsing that understanding depends upon interpretation. Similarly, it has been argued that IPA seeks to examine by what means participants make sense of their experiences and actions. It also simultaneously acknowledges that the researchers’ own concepts and beliefs should be known in order to apprehend the phenomena being studied through a process of interpretation (Chapman & Smith, 2002).

IPA is also strongly influenced by symbolic interactionism, which states that “the meanings individuals ascribe to events should be of central concern to the social scientist, and also that those meanings occur (and are made sense of)

in, and as a result of, social interactions” (Smith, Flowers, & Osborn, 1997, p. 70). In other words, symbolic interactionism suggests that individuals’ actions are based on the meaning they have ascribed to the stimuli, and that the course of social interaction creates a symbolic meaning dependent on the individual’s interpretation. As Denzin (1995) describes further, individuals subsequently modify their behaviour based on their interpretations of the social interactions. Data obtained from IPA is usually used to generate new models and constructs (e.g., Dahl & Boss, 2005). This is completed through the analysis of the data by creating a number of themes and sub-themes in the form of a narrative, which then provides the researcher with an understanding of these themes allowing their connection in the form of a model (Fade, 2004). As a result, these models could provide useful references for other scholars who intend to study similar phenomena.

### *7.3 Overview, Rationale, and Objectives*

Leading from the findings and limitations of studies one and two, a more in-depth analysis was considered necessary. This was to address these issues and to evaluate the role of ER qualitatively, as well as to inform future intervention programmes. Despite the significant findings in Study One, demonstrating the negative impacts of elevated levels of SA on performance measures, and the findings of Study Two, presenting the efficacy of the ESST-C, the results are limited to some unexpected, non-significant interactions as well as to quantitative measures. Furthermore, in Study Two the results indicated a trend in the same direction regarding SA and ER in children of the experimental as well as the control group. This raises questions over the long-term efficacy of the ESST-C. Although, significant improvements in SA and ER were observed, due to the

social and emotional enhancement skills included, the unexpected, non-significant time x condition interactions call for refinements to the ESST-C. It would, therefore, be useful to evaluate relevant components, such as the role of ER further. Moreover, based on the previous findings that highlighted the severe consequences and impairments of elevated levels of SA and the importance of ER, it was necessary to investigate how children reflect on socially and emotionally challenging situations. Furthermore, additional research is needed into how these are perceived to reduce the risk of developing SAD in the first place. Consequently, and to address the quantitative limitations of the previous research, this study adopts a qualitative methodology and analysis. This aims to further enhance our understanding of the phenomenon of challenging situations and the associated behaviours of children within such contexts, by focussing on children's and parents' individual personal accounts. The results of this study aimed to inform existing programmes, such as the ESST-C, and to enhance our knowledge of the application of such programmes in the treatment and prevention of SAD. Undertaking further research in this area is of importance, due to the high prevalence of SAD in young children, and our understanding, to date, of the developmental impact that this can have without treatment (Bruce et al., 2005; Kessler et al., 2005a; Kessler, Chiu, Demler, & Walters, 2005b).

Some of the consequences of SAD have been linked to discernible restriction of social and vocational functioning (Erwin, Heimberg, Juster, & Mindlin, 2002; Saavedra et al., 2010; Stein & Kean, 2000), which are very closely related to emotion dysregulation (e.g., Goldin et al., 2009a; Mennin et al., 2009; Sung et al., 2012). Accordingly, the regulation of emotions is a vital component that needs to be considered in early intervention programmes for

SAD. Meta-analytic research into behavioural and CBT-based programmes with different control groups concluded that each approach was effective in treating SAD (Butler et al., 2006; Chambless & Hope, 1996; Fedoroff & Taylor, 2001). In accordance with this, the most current study by Matthew, Kerns and Ciesla (2014) found that, in a sample of ninety adolescents, SAD symptoms were related to ER difficulties. Hence, it is necessary to enhance our understanding of the individual processes involved in anxiety provoking or challenging situations in order to better inform our formulation of SAD-specific treatment programmes and therapeutic outcome design. A qualitative approach was therefore deemed the most appropriate for inquiry in this area.

Most research available on ER choice, with regard to healthy adaptation, is based on correlational studies involving self-report questionnaires that assess individual differences in respondents' frequency of using different regulatory strategies across situations (e.g., Gross & John, 2003; Nolen-Hoeksema, 2000). Additionally, laboratory experiments have previously been carried out, that involve evaluating spontaneous use of ER strategies in emotional inducing situations (e.g., Gruber, Harvey & Gross, 2012). Although, important links to well-being and various forms of psychopathology are demonstrated (cf. Aldao et al., 2010), these studies are predominantly conducted with clinical adult samples. In addition, the available research does not assess the factors that influence individuals to primarily prefer using a particular regulatory strategy over another. Furthermore, other studies have not looked into which ER strategies are chosen in particular emotional and, or, social contexts and instead, either instructed participants to apply certain regulation strategies or asked them on the basis of self-report questionnaires (e.g., Goldin et al, 2009b).

The current study, therefore, aimed to address these limitations, and dearth of research, by looking into how emotions are handled and the determinants of the ER choices that children make, when it comes to socially and emotionally challenging situations. It also included their parents' perception of these choices to acquire more information on this matter. It is hoped that the findings of the present study may reveal influential factors, which may help discover emotion- and social-related processes that contribute to the aetiology or maintenance of childhood anxiety (e.g., Lonigan, Hooe, David, & Kistner, 1999). As reported in several studies, children who experienced "anxious symptoms relied on inhibited and dysregulated methods to manage their scared, sad, and angry feelings to the neglect of adaptive regulation strategies" (Suveg et al., 2001, cited in Suveg & Zeman, 2004, p. 750). Furthermore, the findings by Suveg and Zeman (2004) support the notion that difficulties in regulating emotions appear to be a component of most forms of psychopathology (e.g., Bradley, 2000). Their results suggested more dysregulated expression of anger, worry, and sadness in children with an anxiety disorder, as opposed to children without one. Taking into consideration that the development of ER strategies depends on the emotional experiences of individuals, as well as the potential higher risk for children and adolescents to develop SAD (Rapee & Spence, 2004), the current study will examine children going through this stage of transition.

Therefore, in order to understand ER from the child's perspective and to acquire a more qualitative approach in this matter, children and mothers that had no knowledge of the background of this research were interviewed. In addition, qualitative research into ER tendencies in children, to our knowledge, is under-

developed. In terms of their relevance to psychological disorders and programmes that aim to support children's healthy development, it is highly valuable and essential to investigate these tendencies. Existing research into SAD and ER in children has been predominantly quantitative with a clear focus on process variables and outcomes (e.g., Crawley et al., 2012; Fresco et al., 2013; Mennin et al., 2009). A phenomenological approach would focus on the participants expressed experience. The information acquired could contribute to existing knowledge on this matter by providing an inside perspective of how children perceive their own behaviour and how their mothers perceive their children's behaviours. Consequently, the inclusion of children's and parents' accounts of this can be of importance in evaluating treatment and, or, prevention programmes by combining individuals perspective with CBT and current mental health policies (Department of Health, 1999, 2006, 2007). Relevant features, that are currently neglected in preventive and treatment programmes for SAD, can be highlighted for investigation into their impact, since little is known of these, other, treatment components (McManus et al., 2010). Individual's perspectives, especially of children, have, generally, only received limited attention. This is, particularly, with regard to the processes that occur *within* the child and how they make sense of these experiences within their environment. Hence, this study adopted a phenomenological approach that could afford a research construct in which the participant's response could be expressed openly including their mother's experiences of their child. The interpretative element of IPA can thereby support the sense making of these illustrative accounts in the hope of gaining a comprehensive examination of these experiences.

Together with the requirement of enhancing our knowledge on socially and emotionally demanding situations, which can lead to psychological conditions, such as SAD, it seems indisputable that the personal accounts of individuals contribute to existing literature in research and the treatments offered (Hodgetts & Wright, 2007; Macran, Ross, Hardy, & Shapiro, 1999). In order to do this, qualitative methods appear beneficial due to the increasing recognition that such methodologies are gaining regarding understanding and capitalising upon individual's experiences and insights, within an analytical and epistemologically rational framework (Elliott, 2008; Hodgetts & Wright, 2007). Thus, the present study is applying IPA, which utilises a pragmatic approach to understand the participant's standpoint (Smith et al., 2009) and has become well-established in applied psychology over the years (Brocki & Wearden, 2006; Reid et al., 2005).

IPA is considered an appropriate methodology for the current study as it affords a "capacity for making links between the understandings of research participants and the theoretical frameworks of mainstream psychology," (Smith et al., 2009, p. 186). It has a fundamental epistemological concern with engagement in personal accounts of "the human predicament," (Smith et al., 2009, p. 5). In addition, IPA enables a level of depth, through the insight of the perspective it provides of a particular group of people within a specific context. Given that this research is specifically interested in the experiences of children and past research largely overlooks the personal account, this approach was considered important (Smith et al., 2009). According to Smith and Osborn, IPA is a "suitable approach when one is trying to find out how individuals are



perceiving the particular situations they are facing” and “how they are making sense of their personal and social world” (Smith & Osborn, 2008, p.55).

With the information obtained in the first two studies, the aim of this study was, therefore, to explore the “lived” experience of parents and their children, new to this research, in socially and emotionally difficult situations. The children’s self-perception, parents’ perception of their children, and their behaviour in such situations were, thereby, investigated. The inclusion of the parents’ perception was deemed important, especially, considering the family factors that were discussed in the literature review, possible response biases of children, as well as the additional information that they could contribute, which children may have not been able to articulate. The findings of this study may further help to augment the efficacy and affordability of CBT-based programmes including ER strategies for SAD, by adding relevant programme components.

The overall research question is: How do children understand challenging situations. With the specific sub questions being: (1) How do children experience their behaviour in reflecting on socially and emotionally challenging situations (2) How do mothers perceive their children’s behaviour in reflecting on socially and emotionally challenging situations? (3) How can these findings be used to develop a more sensitive prevention programme for this age group?

### *7.3 Methodology*

This section will firstly introduce the qualitative paradigm that was discussed in Chapter One in more depth. Secondly, it will present the three main reasons for choosing IPA for the current study. Thirdly, the methods will be presented on the participants, the design, and the analytic steps of the data analysis, before discussing the results.

#### *7.3.1 Qualitative Paradigm*

This qualitative study is concerned with examining, in-depth, how children describe and make sense of their experiences of challenging situations. Moreover, the study sets out to explore the meaning of these responses, in the context of their behaviours within these situations. The inclusion of parental data was considered important to support as well as enrich these findings. While, quantitative research is concerned with the measurement and analysis of variables through the use of questionnaires and scales (e.g., Barkham, 2003), McLeod (2003) stresses the emphasis on the collection and analysis of personal accounts of participants' experiences when it comes to qualitative research. The qualitative aim is thereby to explore the meanings of social situations and actions with the view to provide an understanding rather than an explanation. It, therefore, is suggested to be the most suitable methodology when it comes to understanding the meanings that people make of their experiences (e.g., Morrow, 2007). According to Barker and colleagues (2002) qualitative research findings could support the demonstration of unexpected findings. As a result, this may aid the discovery of impediments or facilitators to change, in addition to identifying the reasons for the successes or failures of existing interventions (Starks et al., 2007). Consistent with Ashworth (2003, cited in Smith, 2008), such research

methodologies are more relevant in investigations that intend to study the detailed understanding of an individual's world. As a result, the widely used approach known as IPA (Smith, 1995; Smith et al., 2009) was applied to guide the data collection and analysis.

### *7.3.2 Rationale for employing IPA*

As introduced above, IPA was the chosen qualitative approach within this study. The following summarises the reasons:

Firstly, the phenomenological underpinnings within IPA enable an exploration of the participant's personal experience and perception or account of a situation or phenomenon (Smith & Osborn, 2003). Eatough and Smith (2008, p.179) stated that "IPA is concerned with the detailed examination of individual lived experience", it is "the study or description of phenomena" and thus, phenomenology "involves the description of things as one experiences them" (Hammond et al., 1991, p.1). It is however necessary to take a reflective stance throughout the process, though this has been suggested to be rather challenging as it is difficult to detach from people, objects, language and culture, when making sense of the world (Heidegger's concept of Dasein, 1962/1927; Conroy, 2003). The researcher in IPA therefore uses reflexivity in an attempt to examine lived experience in detail, whilst acknowledging the role of inter-subjectivity (Smith et al., 2009).

Secondly, IPA recognises that in order to obtain direct access into an individual's lived experiences the researcher will inevitably use their own view of the world. Accordingly, the analysis produced has to be recognised as an "interpretation of the participant's experience" (Willig, 2001, p.53). Due to the double hermeneutic, IPA recognises that it is never truly possible to gain a

complete insider's perspective (Smith & Osborn, 2003). However, through the use of interpretation within IPA, this can be endeavoured (Biggerstaff & Thomson, 2008). Furthermore, the systematic and detailed analysis of the text will achieve this through the connections, which emerge from the greater data set, in addition to the discussion with psychological theory (Smith et al., 2009). By interpreting the transcripts both critically and interpretively and providing a balance of 'empathetic hermeneutics' and 'questioning hermeneutics', the research can provide a true account of a given phenomenon from the participant's perspective.

Thirdly, with an emphasis on ideography, IPA achieves a level of depth when providing insight into the perspectives of a specific group of people in a specific context. This was considered important, given that this research is specifically interested in the experiences of children in challenging situations and that previous literature had largely neglected these insights. IPA provides an understanding of the researched phenomenon in an analytical way, that looks into each case before any endeavour is made, to assign a generalised interpretation of the experiences onto the sample population (Smith & Eatough, 2007). Additionally, it pursues discovery of the meaning of being in the world by examining the phenomena and structure of that world. It, thus, enables the researcher to gain an understanding of an individuals' involvement and comprehension of their world (Smith et al., 2009). Semi-structured interviews were conducted with 9 children and their mothers aiming to understand how children perceive and experience their own behaviour in socially and emotionally arduous situations and how they rationalise their responses or behaviours, including their parents' accounts.

Based on the aforementioned, qualitative paradigms such as IPA provide the opportunity to develop an idiographic understanding of participants and the meaning they ascribe to a particular situation or condition that they live with (Bryman, 1988). Consequently, certain complex phenomena can be understood, and clinical practices can be informed and thereby improved in order to become even more advantageous (Boyle, 1991; cited in Harper & Warner, 1993). According to Smith and Osborne (2008), IPA has an ethical and theoretical commitment to the participant as a cognitive, semantic, physical, and affective being. It suggests a sequence of connections between peoples' talk, their thinking, and their emotional state. However, this sequence may be rather complicated when the participant presents difficulties in expressing their thoughts and feelings. Although there may be reasons why this is the case, the researcher can only interpret peoples' mental and emotional state from what they say. The sense making by the participant and researcher, which is the emphasis of IPA, offers cognition as a central analytic concern (Smith & Osborne, 2008). Accordingly, IPA shares the approaches of cognitive psychology as well as social cognition in social and clinical psychology (Fiske & Taylor, 1991). Yet, it separates from conventional psychology in terms of selecting the appropriate methodology for certain questions. Conventional psychology, for instance, tends to apply more quantitative and experimental methodologies. IPA, conversely, employs profound qualitative analysis, which, despite their common interest in examining how people think about something, separates IPA and conventional psychology.

By applying IPA, researchers commit themselves to investigate, discover, interpret, and situate the meanings through which participants make sense of

their experiences (Larkin, Watts, Clifton, 2006). Thus, besides trying to make sense of the participant's experiences, it allows the researcher to produce a theoretical framework that is based upon. Though, this framework may transcend or exceed the participant's own terminology and conceptualisation (Smith, 2004). The epistemological openness of an IPA approach allows cautions and interpretations about discursive, emotional, and cognitive phenomena and is therefore unique among qualitative approaches in psychology (Smith, 1996). According to Reid, Flowers, and Larkin (2005), this explains the expansion of IPA in the areas of applied psychology.

### *7.3.3 Alternative Methodologies*

During the development phase of this research other methodologies such as Thematic Analysis, Discourse Analysis, and Grounded Theory were considered. However, since the main concern of thematic analysis is to identify patterns within the data (Marks & Yardley, 2004) and, as such, is more theoretically bound, this approach was not appropriate. Given the interest of the current project in investigating the meanings present in children's and parents' descriptions of challenging situations, a more interpretative stance was needed. Additionally, the emphasis on phenomenology, which can be found in IPA as opposed to thematic analysis, was necessary (Braun & Clarke, 2006). Comparably, discourse analysis was not appropriate for the current project, since the main focus of discourse analysis is on the language used to describe an experience rather than the meaning (Potter, 1996). Meaning and understanding is, however, of great significance to the overall research question of this thesis.

With regard to grounded theory, this methodology examines context, causes, eventualities, consequences, conditions, and co-variances in order to

understand the patterns and relationships between these elements (Strauss & Corbin, 1998, cited in Starks & Brown Trinidad, 2007). Conversely, the current research is concerned with the exploration of children and parents' experiences rather than the description and explanation of simple events within the environment in which they are studied (Glaser & Strauss, 1967, cited in Starks & Brown Trinidad, 2007). In addition, as Starks and colleagues (2007) highlight the aim of grounded theory is to produce a specific theory as the end product, yet the current research aims to focus more on exploring how participants make sense of their own experience which is in line with IPA (Brocki & Wearden, 2006). Lastly, IPA seemed suitable given its emphasis on ideography rather than a wider conceptual explanation (Smith, Flowers & Larkin, 2009).

## ***7.4 Method***

### ***7.4.1 Participants***

According to Smith and Osborn (2008), the sample size of IPA studies is generally rather small (usually five to six participants). This is due to an investment in the analysis of individual in-depth accounts rather than focusing broadly with an objective to generalise beyond the scope of the individual context. For the purpose of the current study, a total of nine children and their mothers (nine) were used. This sample size was deemed appropriate, as two groups of participants were involved. Parents and children who had not participated in any other study within this research were recruited from the participating schools. The sample consisted of 2 girls and 7 boys aged 7-12 (Mean=8.67, SD=1.87), and 9 mothers, aged 38-58 (Mean=47.22, SD=7.82). Consistent with sampling in IPA (Smith et al., 2009), the sample of the current study was fairly homogenous. As evaluated in more detail in the previous, the

additional use of parental data was considered relevant, as this also provides further support of the subthemes that emerged and reinforced what appeared to be the children's regulatory styles. Expanding this research by including parents' experiences of their children's behaviour in socially and emotionally challenging situations could inform future programmes that aim to reduce the development of SAD further.

With regard to the exclusion criteria, and for the purpose of the current study, children whose parents made us aware of any clinical diagnosis were excluded from the analyses. No children were known to have a clinical diagnosis of any kind, so the sample size was retained. In addition, the decision to only include children aged 7 to 12, in the present study, was informed by existing research suggesting the age of onset for SAD to be between 7 – 13 years (e.g., Beidel & Turner, 2007; Costello et al., 2011; Knappe et al., 2011).

Table 7.1: Participant Child Demographics

<b>Pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnic Origin</b>	<b>Siblings</b>	<b>School Year/Occupation</b>
Michael	Male	8	Other Mixed Background	1 Brother	3
Ryan	Male	8	Other Mixed Background	1 Brother	4
Lewis	Male	7	Other White Background	1 Brother	3
Luke	Male	12	White British	1 Brother	7
Richard	Male	10	White British	1 Brother	5
Mark	Male	8	White British	2 Sisters	4
Monica	Female	11	White British	1 Brother, 1 Sister	7
James	Male	7	White British	1 Sister	2
Tina	Female	7	White British	1 Brother	2



Table 7.2: Participant Parent Demographics

<b>Pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnic Origin</b>	<b>School Year/Occupation</b>
Linda, Mother of Michael	Female	41	Other Mixed Background	Part-time Receptionist
Danielle, Mother of Ryan	Female	44	White British	Computer Programming
Sandra, Mother of Lewis	Female	38	Other Asian Background	Housewife
Nicole, Mother of Luke	Female	58	White British	Housewife
Nicola, Mother of Richard	Female	58	White British	Housewife
Cindy, Mother of Mark	Female	41	White British	Entrepreneur
Mandy, Mother of Monica	Female	41	White British	Entrepreneur
Stacey, Mother of James	Female	52	White British	Housewife
Stella, Mother of Tina	Female	52	White British	Housewife

#### *7.4.2 Ethical Considerations*

Prior to the commencement of this study, ethical approval was obtained from the Ethical Board of the University of Roehampton (Appendix I). On approval participating schools from Study One and Two published an advertisement in their schools newsletter. Those parents who volunteered for the study were provided with a letter of invitation explaining the project (Appendix XIX) followed by a consent form, which they were asked to complete for themselves and their children (Appendix XX). In order to gain obtained consent, this form explained the primary objectives of the study and further assured participants that

all data acquired would be kept confidential and that they have the right to withdraw at any time. When issued with the consent form, participants were made aware that: all information provided would be used with sensitivity and discretion throughout the reporting of this work, which may be published or used for presentation purposes. The interview would be audio recorded, solely for transcription purposes to ensure an accurate account and understanding of the conversation. Data would be stored, separately from any identifiers, on a personal laptop computer, in order to maintain anonymity at all times and pseudonyms would be used to refer to participants. Prior to signing the consent form participants were given the opportunity to ask any questions they may have regarding the study. In terms of any potential distress that may be experienced by the participants, a debriefing process was offered to discuss any issues that arose and answer any questions that may have arisen. In addition, participants were provided with a list of sources of support on the debriefing form (Appendix XXI).

#### *7.4.3 Procedure*

The research was initially discussed with the headteachers of the schools that participated in the previous studies of this research. This was conducted to clarify both the interests of the researcher and the school in terms of their pupils. On institutional approval, children and parents were invited to take part in this study through the participating school's newsletter. Interested parents and children were provided with a letter of invitation (Appendix XIX) that invited them to an individual interview lasting between 30-60minutes. Suitable interview dates and times were arranged with the participants individually. The majority of interviews took place at the school, whilst others were conducted at the

University. On arrival participants were welcomed and reminded of the nature of the research, their rights as participants, the process of the research, what would be required of them, and provided with the opportunity to ask any further questions. If happy to proceed, participants were asked to sign the relevant consent form (Appendix XX). After written consent was obtained, semi-structured interviews were conducted, which were prepared prior to the study in accordance with the recommendations of Smith and Osborn (2003) and based on some measures used in the previous two studies.

Participants were interviewed using semi-structured interviews with open-ended questions, as this provides a response format that is not previously determined or constrained by the researcher. This enables data generation to be constructed by the participants rather than being controlled by the researcher. The questions were designed to encourage participants to talk about their experiences of socially and emotionally challenging situations, their behaviour and rationalising of their conduct in such situations. The participants were additionally questioned about the way in which they see their parents and siblings. However, due to space restrictions, these extracts were not included in the current analysis and presentation of results. The primary researcher of this project carried out the interviews with each child individually and then with their mother followed afterwards. This aids the generation of accounts in different social context and removes child-parent demand characteristics. The interviews with the parent were approximately 45-60 minutes long, whilst the children interviews ranged from 30-40 minutes. All interviews were tape-recorded. Prior to the interview, parents were asked to complete a questionnaire designed to

obtain demographic information for statistical purposes. These took approximately two minutes to complete.

#### *7.4.4 Debriefing*

At the end of the study, children were debriefed verbally and thanked for their time and participation. Each parent was provided with a debrief form, outlining the full nature of the study, whilst also reminding them of the confidential treatment of all information obtained and data generated (Appendix XXI). Participants were given the opportunity to ask the researcher any other questions that they may have and given contact details. If the participant had any further concerns regarding the study, they were advised to contact the principle investigator, the schools' SENCO, the Director of Studies, and/or the Head of the Psychology Department (see Appendix XXI).

## *7.5 Design*

### *7.5.1 Semi-Structured Interview*

As outlined in 7.4.3 semi-structured interviews were used to obtain rich subjective data from both children and their mothers (see Appendices, XXIII; XXIV), as this is considered effective in eliciting participants' accounts about a target phenomenon (Smith et al., 2009). Consistent with the ideographic nature of IPA, which was elaborated on in chapter 7.2 and 7.3.2 the interview is aimed at accessing a first-person account of the individuals' experience through slight probing only to enable participants to speak openly and reflectively in some depth (Smith et al., 2009). Given the research interest in the specific phenomenon of socially and emotionally challenging situations and the way they are responded to, semi-structured interviews appeared most illuminative. Specifically considering the participants also consisted of young children.

### *7.5.2 Interview Schedule*

The interview schedule (see Appendices XXIII, XXVI) was constructed and used as a flexible guide (Smith et al., 2009), as this enables an authentic every-day interaction that was being investigated. As mentioned in 7.4.3 open-ended questions were prepared with possible prompts to encourage the participant to provide detailed accounts of their experiences and expand on their responses. The questions developed were based on previously used and validated SA and ER questionnaire measures.

## *7.6 Data Analysis*

The recordings were transcribed verbatim to appear as written text and to simplify the analysis. As qualitative analysis is interested in the informational content of the data, the transcriptions focused on what participants said about their own experience and also included some indicators of emotion (e.g., pauses, notation of laughter, or other expressions). However, it is important to recognise that any interpretative transcription of discourse cannot fully represent an exact demonstration of the phenomenon as it occurred. The transcriptions were compared to the recordings again after completion of transcription to ensure accuracy and reliable representation as far as possible.

The analytic process followed the standard procedures outlined by Smith and colleagues (e.g., Smith et al., 2009; Smith & Osborn, 2003). Initially, verbatim transcripts of the audiotaped interviews were generated (see appendices XXV, XXVI for a copy of a parent and a child interview transcript). The data from all transcripts were analysed using the following analytic process for IPA (Smith et al., 1999):

1. Transcripts of each interview were read several times and notes were made about anything that appeared of significance in regard to children's experience of challenging situations and the perception parents had on their child in such situations.
2. The transcripts and notes were re-read and emerging themes were noted while an attempt to read the interview with an open mind was made.
3. On completion of steps 1-2 any emergent themes were identified and organised into preliminary clusters. At this stage, the aim was to develop a group of themes that enable the identification of super-ordinate categories, representing

three master-themes. The aim was to look for clusters of themes, which reflected and shaped aspects of the child's experience, as well as their perception of themselves in challenging situations and their parents' views on them. After the clusters of the themes had been identified, the data was re-examined to identify any other statements, which could be included in the clusters.

4. Considering the clusters of the themes themselves these were examined and the inter-relationship between them was deliberated. Those clusters that inter-related, were grouped together into a smaller number of domains.

5. A table was produced that included sections of the participant's transcript which disclosed the participant's core thoughts and emotions about their experience in relation to each domain. The analytic themes were then translated into a narrative account. The shared themes within each of the domains were organised to enable consistent and meaningful statements concerning the participants' own experiences that were rooted in their own words. Correspondingly, themes were generated based on the participant's experience, consistent with the phenomenological tradition rather than on pre-conceived hypotheses about the topic.

Another experienced qualitative researcher then reviewed these data sets and analyses, in order to assist in the identification of researcher bias and/or imposition in the data-analytic process. According to Heidegger (1962/1927, cited in Smith et al., 2009), it is rather challenging for humans to detach themselves from other people, objects, language, and culture during the process of making-sense of views. Thus, reflexivity, which is the "researcher's contribution to the construction of meanings throughout the research process" (Nightingale & Cromby 1999, p. 228), is used by the researcher in IPA. The

reflective stance will enable the detailed examination of lived experiences, whilst acknowledging the imposition of one's own subjectivity. It is further important to keep the inductive feature of IPA in mind, considering that the current research questions are not based on hypotheses that need to be tested. The focus is rather on discovering what transpires during the analysis that assists an expansive range of data to be accumulated. In line with the aims of the current study, this profundity was required to produce a wealth of data rather than constrained findings, such as with previous quantitative research in this field. Accordingly, Smith and colleagues (2009) stated that IPA analyses provide meaningful insights that go beyond, although incorporating, the precise statements made by participants.

#### *7.6.1 Validity and Reliability*

In accordance with Yardley (2000) the current research followed four extensive principles for validity and reliability: (1) 'sensitivity to context', which refers to demonstrating sensitivity to the raw data, existing literature and environment of the participant; (2) 'commitment and rigour', which entails the researcher's commitment to show thoughtfulness towards their participants, during the interview, as well as the data analysis and rigour, that requests a systematic approach to the study; (3) 'transparency and coherence' that signifies the researchers open and precise presentation of the research process. Representing the recruitment of participants, the way in which the interview schedule emerged and was conducted, as well as the steps undertaken in data analysis, is how this can be enhanced. (4) 'impact and importance', which, according to Yardley (2000), refers to the question of whether or not the research states something interesting, imperative, or advantageous. To ensure validity, it is crucial to keep



in mind that all research is unique, Smith and colleagues (2009, p. 184) commented, “Validity will need to be flexibly applied”. Furthermore, a qualitative scholar checked several transcripts and themes, providing a wider perspective on the accounts of participants and to enable a comparative analysis of the researcher’s interpretations with that of another individual. This helped identify researcher bias improving the validity of findings, to enhance the methodological rigor, and finally the reliability of the analysis (Elliott et al., 1999; Smith & Osborn, 2003).

#### *7.6.2 The Researchers’ Reflexivity*

Throughout the interview, full attention was provided to the participant in order to facilitate a truthful analysis of each transcript and to facilitate the nearest interpretation and theme identifications possible, to the participants’ descriptions of their experiences. The commitment to diligence, the detailed and systematic analysis process, as well as the interpretative nature of the analysis were demonstrated in the previous sections. Furthermore, the chapters and appendices provided, aim to aid the transparency and coherence (in line with Yardley, 2000). All relevant paperwork and audios have been stored to be available upon request. This ensures reliability and transparency as they can be compared to live recordings that were transcribed verbatim. The additional consideration of the themes by an experienced qualitative researcher, outside the supervisory team, supported a trustworthy and neutral examination of the data and the resulting findings (in accordance with Creswell & Miller, 2000). However, all qualitative research has to acknowledge the researcher’s limitation and imposition on constructing and analysing data in these frameworks (cf. Fischer & Wertz, 1979).

The peer review helped to challenge personal assumptions and to question methods and interpretations.

The need for self-reflection within qualitative research is consistently highlighted (Smith et al., 2009; Brocki & Wearden, 2004). Thus, throughout the research, self-reflection notes were made including recordings of own responses to the interview schedule. This allowed for an exploration of any preconceptions, judgments or attitudes in IPA in order to meet good practice recommendations (e.g., Banister, Burman, Parker, Taylor & Tindall, 2003). The exploration of the researcher's subjectivity is essential in identifying the position of the researcher, with regard to the definition of the problem and the way in which the researcher interacts and makes sense of the material. Consequently, the researcher is enabled to get as close as possible to the objective account of the phenomenon in question.

## *7.7 Results*

### *7.7.1 Overview*

The results of this IPA analysis are understood as one of many possible readings. The findings that are highlighted here identify three distinct styles of emotion regulation from children's accounts, reflecting on their experiences of socially and emotionally challenging situations. In addition, these children's mothers were also interviewed and gave their understandings of their child's possible behaviour in these stimulus situations. It is acknowledged that the inclusion of the parental data, while not sustaining a phenomenological focus on the main group of child participants, was considered useful to supplement where their children could not fully articulate their own experiences. The three master-themes identified from the eighteen semi-structured interviews focus on qualitative differences in these children's and their mother's reported accounts, named as follows:

- ❖ Avoidant ER Style – Reported avoidance or prevention of feared emotional states based on children's sensitivity to social perception
- ❖ Conflicted ER Style – Reported inability to control/adjust a conflictual emotional state
- ❖ Focused Relational ER Style – Reported capacity to express, relate to, modulate an emotional state, and/or maintain a positive state

Table 7.3 below summarises these three master themes and their constituent sub-themes.

Table 7.3: Three Emotion Regulatory Styles

Master-Themes		
<b>AVOIDANT ER STYLE</b>  Reported avoidance as prevention of feared emotional states based on children's sensitivity to social perception	<b>CONFLICTED ER STYLE</b>  Reported inability to control/adjust a conflictual emotional state	<b>FOCUSED RELATIONAL ER STYLE</b>  Reported capacity to express, relate to, modulate an emotional state, and/or maintain a positive state
Constituent Sub-Themes that illustrate distinctive components of ER		
<i>Cautiousness in disclosing emotions</i>	<i>Reluctance in talking about conflictual emotions (Internalisation)</i>	<i>Confident fluency in expressing emotions</i>
<i>Deflection of embarrassment</i> <i>Apprehension of being exposed to anxiety-provoking emotions</i>	<i>Struggles to regulate overwhelming, conflictual emotions</i>	<i>Capacity to regulate inhibiting emotions</i>
<i>Caution in modulating the feared emotional state</i>	<i>Inability to contain conflictual emotions</i>	<i>Self-supportive minimising of undesirable emotions and/or maintenance of positive emotions</i>

These master themes and their related sub-themes will be illustrated and discussed to explore children's reported reactions in more depth. For the purpose of brevity, only a limited selection of the many available exemplar quotes was included (see appendix XXVII for further examples of related quotes for each regulatory style). As indicated above, it is important to acknowledge that in two of the sub-themes ('Apprehension of being exposed to anxiety-provoking emotions' and 'Reluctance in talking about conflictual emotions') there was a

dearth of children's quotes, possibly due to the subtlety of the psychological experiences, which the parents seemed to be able to explore. Here, in particular, the parental data offered useful supplementary data to illustrate the distinctive features of each regulatory style.

Utterances such as 'Mmm' and hesitations are indicated appropriately and brackets indicate material that has been added for explanatory purposes. All participant quotes are indicated in italics. In order to maintain anonymity of participants, pseudonyms have been used (see Table 7.1 and 7.2 of Participant Demographics) and where appropriate "I" is used to refer to the interviewer.

*7.7.2 Master Theme (1): Avoidant ER Style: Reported avoidance or prevention of feared emotional states based on children's sensitivity to social perception*

The first master-theme aims to capture the reported avoidant reactions of some of the child participants to their (and their mother's) reflections of the anxiety-provoking scenarios. The distinctiveness of this regulatory style compared to the other two was evident in these children's reference to quitting social activities or avoiding social scenarios that appeared negative to them based on their sensitivity towards social perception.

*7.7.2.1 Cautiousness in disclosing emotions:*

The first sub-theme addresses the children's caution in disclosing their emotions. The notion of cautiousness in this context is understood as a way of avoiding revealing emotions in a challenging scenario presented, in order to protect oneself. For example, Monica and Mark talked about how best they tried to avoid displaying any emotions in response to my question:

*I: "...what do you think made you feel upset or stressed out about this?"*

*M: "Mm because I knew she'd (the teacher) be quite angry and I was kind of not really looking forward to the time when I might have to explain it." (Monica, 3, 76-78).*

*I: "...so how did you behave, what did you do?"*

*M: "Well I just kind of, I was speaking quite quietly and I kind of said, you know, explained it and kind of didn't say much." (Monica, 3, 79-81).*

*I: "...what do you usually do when you are really upset or stressed out about something?"*

*M: "... I just, like, go somewhere and, like, just act normal in that place, just, like, after two minutes, so, like, lock the door so no one can get in and then just go out after the two minutes and just be, like, really normal; if you're sad and you don't want anyone else to know."* (Mark, 5, 129-132).

In these extracts, both children indicated a level of discomfort associated with disclosing their emotions and therefore trying to hide them. For example, Monica referred to *"not really looking forward to the time when I might have to explain"* and *"not saying much"* or *"speaking quietly"*, through which she described how, she had to contend with the distress in explaining herself and her resulting caution in disclosing her emotions. Mark on the other hand, talked about physically removing himself to avoid being seen by others *"I normally just like go to somewhere quiet, which like you can lock the door like..."*. There appears to be a similarity in these children's behavioural responses to negative emotions. Although they were using different ways of avoiding, they both seemed to do so by displaying caution in disclosing their emotions. Furthermore, there seems to be a particular understanding in both accounts that Monica and Mark experienced embarrassment or sadness as a form of weakness and, therefore, appeared self-protective about disclosing any of this to others.

Monica's mother, Mandy, James' mother, Stacey, and Mark's mother, Cindy, also commented on their children's behaviour in relation to my question:

*I: "And how would you describe her behaviour in those challenging situations?"*

*M: "Mm (thinks) well she, I think she gets quite defensive, mm, and (thinks) I think it's a false kind of, she can come across kind of rude and, mm, quiet, not*

*say very much, so I mean that's how she deals with it..."* (Mandy, Monica's mother, 8, 9, 272-275).

*I: "So in terms of behaviour you would say he would avoid those situations and how does he experience those situations?"*

*S: "...I mean, I can see him using avoiding tactics which other people might not (...) he can get stubborn or cross, so if someone perhaps, again not knowing, tries to encourage, you know, he'll start a bit, "oh it's stupid I don't want to do this, it's stupid" you know, that kind of, so attacking what it is that he's trying to avoid. (Stacey, James' mother 14, 442-447).*

*I: "Why do you think he experiences these situations as challenging?"*

*C: "I think he's very worried about embarrassing himself and very worried about how he comes across..."* (Cindy, Mark's mother, 6, 166-167),

*C: "...he's very aware, he says he's very aware, of how he behaves and he, and that, you know, will dominate, you know, how he behaves..."* (Cindy, Mark's mother 6, 171-172).

Mandy and Stacey described the avoidant and defensive ways in which their children seemed to cope in socially and emotionally challenging situations in order to avoid disclosing any related emotions. Mandy referred to Monica coming *"...across kind of rude and, mm, quiet, not say very much..."*, while Stacey explained her son James *"using avoiding tactics (...) he can get stubborn*



*or cross... ”*. Mark’s mother Cindy explained the reason why her son may also present this caution. She justified her son’s sense of cautiousness in disclosing emotions, using his apparent concern of humiliating himself. This further underlines his sensitivity to social perception. Furthermore, it comes across that both Mandy and Cindy seem empathetically attuned to their children’s wariness.

More generally, this sub-theme illustrates the reported caution in children when it came to the exposure of any emotions in challenging situations. This appeared to occur in children, when they tried to protect themselves from this disclosure, by disregarding or avoiding talking about it. In particular, children’s sensitivity to social perception was evident, which may explain the resulting defensive regulatory style.

#### 7.7.2.2 Deflection of embarrassment:

In contrast to the previous sub-theme, the following illustrates another aspect of the first master-theme, Avoidant ER Style, by presenting what children reported about their experiences of socially difficult situation and the related emotions. In particular, the second sub-theme aims to reflect the reported deflection of embarrassment in children. For example, James and Lewis stated:

*I: “What do you do when you are upset about something?”*

*J: “Sometimes, actually this is true, but, actually it is true, when I get told off I just try and smile.”* (James, 4, 106-107).

*I: “Can you think of any events where you felt uncomfortable because of other people around you?”*

*L: "... (thinks) mm, I'm quite nervous with one person, because I really don't like him and, mmm, when I play, he says that I play bad football, but I don't like him really, because I am ten times better than him and he's bad, actually."* (Lewis, 2, 54-57).

When reflecting on what they might do or have done in a challenging situation, both children seemed to use deflection from their actual emotions by reporting a different emotional state outwardly to that which they felt internally. While James' quote could be indicative of his attempt to deflect from showing his embarrassment about the situation by smiling, Lewis deviated from a possible negative revelation of his skills by pointing out his peer's shortfalls "*he's bad, actually*". His reference to feeling nervous around this person appears to underline the anxiety and negative emotions he associated with him, as his peer seemed to expose an unfavourable image of Lewis, which Lewis ostensibly wanted to avoid. Seemingly, the Avoidant ER Style of deflection 'protects' both children from the anxiety associated with the situation and the possible revelation. Again, the sensitivity of social perception, hereby, became apparent.

Interestingly, both children's mothers also reported this component of Avoidant ER Style in their sons:

*I: "...how does he experience those situations?"*

*S: "...at football he might suddenly have a fall and he'd probably make it last a long time (...) I think he's learned a few strategies and maybe it's that the things he needs to avoid are easier to avoid (...)"* (Stacey, James' mother, 14-15, 450-459).

*I: "...how do you think he experiences such challenging situations?"*

*S: "So if he, for example, he reads something and he reads in such a way, mm, because his English is not perfect and he tries to read it very, mm, low voice so I don't understand whether he pronounced it well or not and I understood that he does it by purpose just to hide his weakness..." (Sandra, Lewis' mother, 7, 191-194).*

Both mothers reported that their children appeared inclined to deflect from their weakness in situations where they fear any embarrassment, or failure may be revealed. Furthermore, this seems to occur when they are unable to physically remove themselves from the situation. While Stacey, James' mother, referred to him diverting to a prolonged fall, Sandra, Lewis' mother, explained her sons' deflection from revealing any possible mistakes in reading by 'using a very low voice, just to hide his weakness'. The underlying understanding that not being good at something is a shortcoming may suggest the reason why both James and Lewis seemed to want to conceal this exposure and possibly prevent any embarrassment through deflection.

Overall, this sub-theme reflects the reported difficulty children seemed to experience in relation to accepting and revealing any personal shortcomings and their resulting desire to deflect from this distress. It further indicates that, this type of the Avoidant ER Style may be related to the children's perceived view of others' negative appraisal of them.

#### 7.7.2.3 Apprehension of being exposed to anxiety provoking emotions:

Contrary to the other sub-themes of the first master-theme, Avoidant ER Style, the present one reflects the children's heightened nervousness of being exposed to a feared situation and the related emotions. The notion of apprehension in this context is understood as the nervousness that children seemed to experience prior to the exposure to a socially or emotionally challenging situation. The reported avoidant behaviour that occurs as a result of this, prior to encountering the challenging situation represents another distinct, constituent, sub-theme of the Avoidant ER Style. This sub-theme was best illustrated by the parents' quotes. Though, there was no specific reference to this theme from children, the fact that parents described this underlined the importance of addressing this sub-theme in the overall findings reported. For example, James' mother, Stacey, and Mark's mother, Cindy, described:

*I: "And what would be an emotionally challenging situation for Mark?"*

*C: "An emotionally challenging situation for Mark mm I think having to perform in public at anything really mm he used to belong to a football team and because they were a particularly good football team and there were some really good players he just, if he was running for the ball and someone else in the team was going, he would just stand back and let them go and there was always this constant kind of fear of doing something wrong and you know, getting the ball from the opposition or something like that he would always just stand back and, and it just meant that he never played really." (Cindy, Mark's mother, 10, 315-322).*

*I: "...what would be a socially challenging situation for him?"*

*S: "...I think he definitely has an avoidant, if anything were his, that would be testing, reading or anything he is not good at really, but in the context I was talking about, it would be reading and writing. So you know, he certainly wouldn't want to, mm, read in public, or any games, he would avoid games where perhaps some of it would involve reading, I guess, and you know, he sort of, when he goes to someone's house and, you know, someone is wanting to do a bit of craft work or you know, he would probably just say "no I don't want to do that", or let's play a certain game, something he's particularly good at. So he would avoid, yes."* (Stacey, James' mother, 13, 411-418).

Both mothers referred to the Avoidant ER Style, based on the anxiety associated with being exposed to challenging performance situations and the contingent emotions. Judging by the parents' accounts above, it would appear that their children experienced a significant level of tension based on the anxiety of having to face what they feared. So, in order to escape this tension, the children seemed to avoid engaging in such an activity, or quickly abandon that activity completely. It seems that the children's primary avoidant style of refusing to join in, or quitting, is employed in the first instance as a protective approach, given the mothers' accounts of their children's tension in confronting the anticipated emotion.

*I: "And what do you think is the most challenging aspect for James in those situations?"*

*S: "Mmm (thinks), guess peer group pressure a bit, especially boy peer group pressures. He will use language like "oh boys don't do that you know, mummy", mm, so, mm, yeah, I think there is that peer group pressure really, I think. And*

*not wanting to look like one of the boys, so therefore let's avoid it. That's my guess, mm (thinks), and yeah you know, I think, I feel like there is bit of a common theme going on where you just get stuck in a thread, but I guess it's about not wanting to look silly, not wanting to look like you are stupid, you know, all of those things really."* (Stacey, James' mother, 15, 467-473).

Stacey further justified these tendencies towards this avoidant style with the group pressure her son James might be experiencing and his desire to fit in and belong. As in the previous sub-themes, the sensitivity towards social perception, thereby, becomes apparent, especially with her reference of him not wanting to look "silly" or "stupid". Therefore, not participating in activities in the first place is what makes this sub-theme distinctive from the others. In addition, Stacey and Cindy, in particular, seemed sensitive towards their sons' behaviour by inferring that this is a typical human response, where an individual is keen to be accepted by others.

On the whole, these quotes within this sub-theme reflect the parents' reported sense of apprehension in their children before they are exposed to the anxiety-provoking situation, the related emotions, and their resulting avoidant behaviour. This appeared to occur in these children when they tried to protect themselves from having to face the feared emotion. Moreover, this could imply a rather low to non-existent capacity in these children to confront what can be, or is anticipated to be, troubling in any way, even to the extent of not wanting to be involved in an activity at all.

#### 7.7.2.4 Caution in modulating the feared emotional state:

In contrast to the previous, the final sub-theme reflects the stage in which children did not seem to have the opportunity to avoid a situation and the feared emotional state and, therefore, appeared challenged to respond to their anticipated emotions. It aims to present how parents and children reported on this confrontation and the caution they experienced in modulating the challenging emotions that are aroused in the stimulus situations talked about. It seems as if the caution the children seemed to experience led to their withdrawal from the challenging situation, presenting another distinct component of the master theme - Avoidant ER Style. For example, Michael and Luke explained:

*I: “ And what did you actually do in that situation?”*

*L: “I was just a bit like, eh, not upset but, like, oh no, just like, ahhh, like, annoyed and like, I need to get out of here, oh God.” (Luke, 2, 32-33).*

*I: “Ok, so what do you find most difficult in those situations?”*

*L: “The most difficult bit is when you just found out you can’t do it a bit, like oh no, I can’t even say I can’t do it, or like, you try and you are like, ohh, like, so it’s the most difficult bit is when you actually find out you can’t, that other people are, like, much better than you and you can’t do it.” (Luke, 2, 59-62).*

*I: “Okay, and what do you find most difficult in an embarrassing or uncomfortable situation?”*

*M: “Mm (thinks), coping with it.” (Michael, 3, 65-67; 64-66 in the appendix).*

The above extracts are illustrative of the challenge both children seemed to experience when reflecting on facing the anticipated emotional state. The two main difficulties that can be interpreted from Luke's quotes above are his inability to admit that he cannot do it, which involves others, and the difficulty of the self-realisation that he cannot do it, which is internal. Both illustrate a sense of withdrawal based on the challenge he appeared to experience in trying to regulate the feared emotional state. In particular, Luke's description of the urgency of "*getting out of here*" could be understood as him wanting to prevent himself from any further exposure to the feared emotional state. This may possibly be due to not knowing how to handle the situation. This also became apparent in Michaels' quote of finding "*coping with it*" the most challenging. As such, the negative feelings associated with the situation can underline the caution the children seemed to experience and their resulting desire to withdraw from the situation.

Interestingly, Michael's mother, Linda, described the same dynamic in her experience of her son:

*I: "How do you think he experiences those situations himself?"*

*L: "...he didn't really know how to handle that, I think if he could have run off he probably would have..."* (Linda, Michaels' mother, 14, 432-433; 458-459 in the appendix).

In addition, two further mothers, Cindy, Mark's mother, as well as Sandra, Lewis' mother, elaborated on their son's experiences:

*I: "What is the most challenging aspect for him in those situations?"*



C: *"...if it's something he's done, where he's been messing around he's gone knocked a vase off the table or something, he'd just run off, cause he can't cope with what he, with what has happened..."* (Cindy, Mark's mother, 11, 349-351).

I: *"What would be a socially challenging situation for Lewis?"*

S: *"...for him, challenging is to, mm, if he sees difficulty for example, there was a moment he liked very much swimming (...) so he found it very difficult that somebody was better than him."*

I: *"So he is very competitive."*

S: *"Yes. If, mm, he went to swim and his friend was much better than him, then he stopped. He said 'I don't go to swimming anymore'."* (Sandra, Lewis' mother, 6, 160-166).

Based on these parent accounts, it appears that their children experienced the feared emotions as a challenge and because they did not know how to moderate it, they either removed themselves from the scenario as Linda and Cindy described their sons Mark and Lewis 'running off', or quit the activity entirely, as Sandra explained about her son Lewis. The parents' reflections on their children's withdrawal from socially challenging situations further highlights their children's apparent caution in moderating the feared emotional state as a result of their sensitivity to social perception.

Overall, this sub-theme reflects the reported difficulty these children seemed to experience when they, or their mothers, were reflecting on what it could be like for them in a situation of having to face an anticipated feared

scenario and the related emotions. This seemed to occur when children appeared to feel the need to remove themselves from the situation, as a result of that. They seemed to be caught in the helplessness of misregulating their feared emotions and therefore wanting to protect themselves from experiencing them any further.

To summarise, these four sub-themes illustrate the distinctive components of the first master theme – Avoidant ER styles - by presenting the reported avoidance or prevention of feared emotional states in children based on their sensitivity to social perception. Their avoidant regulatory styles were further based on their ostensible desire to protect themselves from possible social scrutiny. What became particularly apparent was the children's cautiousness in expressing and disclosing any emotions, their deflection of embarrassment, their apprehension of being exposed to anxiety-provoking emotions (which seemed to occur before they were in the situation) and finally, their caution in modulating the feared emotional state (when they found themselves in the situation).

*7.7.3 Master Theme (2): Conflicted ER Style: Reported inability to control/adjust a conflictual emotional state*

In contrast to the first master-theme, the following one aims to capture the emotional struggle reported by the children when talking about themselves, as well as their parents when talking about their children. In particular, the reported inability in modulating a conflictual emotional state evoked by reflecting on socially and emotionally challenging situations is presented. The distinctive features of this regulatory style were more evident in the mothers' accounts of their children and partially in the children's own accounts of conflicted and impulsive tendencies, their internalisation, suppression, and/or experience of difficulties in understanding and adaptively controlling their emotions.

*7.7.3.1 Reluctance in talking about conflictual emotions (Internalisation):*

Distinctive from the first sub-theme of the master-theme, Avoidant ER Style, the current sub-theme of the Conflicted ER Style master-theme was solely reported by the children's parents and exemplifies the children's reluctance in talking about conflictual emotions through isolation and by internalising their emotions rather than by being defensive. The fact that merely the children's mothers resourced this sub-theme may be due to the subtle nature of the psychological experience, which the children may not have been able to express. For example, James' mother, Stacey, and Monica's mother, Mandy, described:

*I: "So how does he experience those challenging situations...?"*

*S: "...he doesn't always want to talk about it so we do tend to give him a minute (...) he would just internalise..." (Stacey, James' mother, 23, 725-726).*

*I: "How do you think she experiences emotionally challenging situations?"*

*M: "...mm, probably underneath it all, she's very upset, but she doesn't show it as much (laughs) so it's a lot harder..." (Mandy, Monica's mother, 10, 331-333).*

*I: "What is the most challenging aspect in those situations?"*

*M: "...she wouldn't run off, she would, it would definitely be a bit more blank, so she's dealing with it all inside..." (Mandy, 11, 351-353).*

When reflecting on how their children might behave when it comes to talking about their conflicted emotions in challenging situations, both parents explained their children's unwillingness and internalisation. While Stacey described James' isolation from the situation, Mandy explained Monica's withholding, which both present the emotional struggle that could be experienced in these children that may have triggered their apparent desire of being on their own or concealing their emotions. It seems as if the experienced internalisation of emotions and withdrawal makes it rather challenging for the children to be comforted and could possibly lead to the maintenance of their unconstructive emotions.

A negative consequence of internalising emotions is further captured in Stella's account of her daughter Tina:

*S: "...and it's really because of the day not because, that's my reading of it, that it's from the day, so I think she bottles up and then explodes really..." (Stella, Tina's mother, 12, 368-370).*

*I: "...can you describe how she deals these situations?"*

*S: "...So yeah, she definitely, she would bottle it up, I think..." (Stella, 12, 377).*

I: *“What about afterwards when she calms down?”*

S: *“...I do think, mm, that to most extent she feels she can’t control it, but having said that, you know, she doesn’t cry at school and I know there are situations, it is very unusually for her to cry at school and certainly not to cry in that way. I’ve never seen her do this, you know, very emotional behaviour in school so we, she can, you know, control it I guess, but she certainly doesn’t feel that she can control it when she is at home.”* (Stella, 17, 542-547).

These extracts illustrate Stella’s implication that Tina internalises her emotions and suppresses her feelings during school. Stella’s reference to *“bottling up”* and *“exploding”* are metaphorical and could exemplify the intensity of Tina’s conflicted ER style of internalising her emotions, which seem to lead to a point of uncontrolled expression. The second extract further represents Tina’s apparent difficulty in expressing her intense negative emotions. This may be due to Tina’s ostensible inability to regulate them and hence, her internalising and suppressing them while in school, which could result in an accumulation of emotions. The negative consequences of this are highlighted at the point of outburst, where, according to Stella, Tina displays them quite intensely, and presents difficulty in calming down or decreasing the negative emotions, which is further illustrated in 7.7.3.3.

Overall, this sub-theme reflects the reported hesitancy in children (based on their mother’s experiences of them) in talking about their conflictual emotions and the negative consequences the internalisation of emotions can have on them. It became apparent that the conflict in ER arises, in this context, based on the

difficulty of being comforted and, or, being in control of the emotions due to the suppression and internalisation of the emotions.

#### 7.7.3.2 Struggles to regulate overwhelming, conflictual emotions:

In contrast to the previous sub-theme, the second one of the Conflicted ER style master-theme intends to capture how the children reflected on their own and how their mothers reflected on their children's reactions to socially and emotionally challenging situations and their struggles in regulating their overwhelming, conflictual emotions. For example, Luke and Tina described:

*I: "Can you give me an example of a recent situation when you were very embarrassed?"*

*L: "Ermmmm (pause) er, when I feel embarrassed. Is it last time, erm, probably like (pause), mm, when you are doing something and someone says some something that's, like, embarrassing but it's true and then you are, like, you don't know what to say." (Luke, 1, 14-16).*

*I: "Why do you think you felt that way?"*

*L: "Cause all my friends found out about it, and it was, like, really awkward cause they were all, like, laughing and I was, like, just standing there." (Luke, 1, 25-26).*

*I: "So why were you embarrassed?"*

*T: "Because I didn't know what to do." (Tina, 1, 24)*

*I: "Okay. And why do you think you felt that way?"*

*T: "Because before every show I feel a little, like, nervous, but I was particularly nervous then because I didn't know kind of what to do..." (Tina, 1, 26-27).*

Luke and Tina referred to their remembered struggles of regulating their conflictual emotions that resulted from socially challenging scenarios. Both of them reported their frustration and helplessness, for example, Luke's use of the word 'just' in "*Just standing there*" and "*Just wait for it to come over...*" further highlights this. Moreover, this informs the Conflicted ER Style, whereby Luke experienced trouble in identifying an adaptive way of regulating these emotions. Similarly, Tina's quotations, particularly her last extract, "*...but I was particularly nervous then because I didn't know kind of what to do*" reflects her struggle in not knowing what to do to regulate her emotions, which seems to contribute to her anxiety.

Interestingly, Linda, Michael's mother, described this struggle when she talked about her son Michael:

*I: "And in terms of emotions what would be an emotionally challenging situation for Michael?"*

*L: "...he battles with letting someone down or saying no." (Linda, Michael's mother, 16, 498; 526-527 in the appendix).*

*I: "How would you describe his behaviour in those kinds of situations, when he is so emotionally challenged?"*

*L: "...think he's, he's, mm, he'd be really torn, he won't know what to do, he'd also be probably flushed..." (Linda, 17, 507- 508; 536-537 in the appendix).*

Linda described her son in a different challenging scenario seemingly experiencing the same difficulties in regulating his emotions. Her account is further indicative of Michael's ostensible feeling of being overwhelmed by conflicted emotions, given her description of a rather *'torn and flushed'* Michael. Furthermore, her inference to him *'not knowing what to do'*, illustrates her sons struggle to understand and manage these conflictual emotions. In particular, her reference to Michael *'battling to let someone down'*, illustrates the reason for the challenge he may be experiencing when it comes to regulating his overwhelming, conflictual emotions.

In summary, this sub-theme reflects the reported struggles in children when it comes to regulating the overwhelming, conflictual emotions that result from a socially or emotionally challenging situation. The distinctive component of the Conflicted ER Style can be understood as the helplessness and difficulty the children appeared to experience when they did not seem to know how else to deal with the emotions generated.

#### 7.7.3.3 Inability to contain conflictual emotions:

The last sub-theme of the second master-theme, Conflicted ER Style, attempts to present the reported inability of children to contain their emotions. Here, the parents' experiences of their child and the child's own experiences, when reflecting on their reactions in socially and emotionally challenging situations, were indicative of feeling unable to contain their conflictual emotions. For example, Monica, James, and Tina explained:

*I: "How do you generally behave in such a situation?"*



*M: "...when I am very nervous, so, I don't really speak much and kind of, I don't know how to explain it, like, kind of, you know, I always go very red and everything." (Monica, 2, 42-44).*

*I: "Okay and why do you think you feel uncomfortable about that?"*

*J: "...I am actually a cry baby (smiles) I am, like I, I, I don't tell others obviously I am a cry baby but I don't sort of like it."*

*I: "So you don't like when you cry?"*

*J: "No. And my, I can't help it but my eyes just build up with water. (James, 2, 40-44).*

*I: "Can you remember anything recently maybe that happened that made you really sad?"*

*T: "Mm, I, when I get told off in Drama.*

*I: "Ah ok, why does that upset you?"*

*T: "Because I start crying." (Tina, 4, 102-104).*

All three children described their unsuccessful attempts to contain their conflictual emotions in different ways, when reflecting on their reactions to socially and emotionally challenging situations. While Monica reported the involuntary exposure of her embarrassment through blushing, both James and Tina referred to uncontrolled crying. In all extracts however, there is a sense of

vulnerability that the children seemed to experience, when not being able to contain their emotions. In particular, James' description of himself as a "*cry baby*" constructs a rather negative way of referring to oneself. It seems that, although, he preferred to conceal this from others; he appeared unable to do so. This is further captured in his account of "*obviously*" not telling others that he is a "*cry baby*", as well as in Tina's expressed frustration of externalising her sadness through crying.

Interestingly, Tina's mother's exemplified this further in her experience of her daughter:

*S: "Maybe yeah, I mean we have talked about that, I mean coming in the house and going upstairs and jumping on the bed, you know that doesn't somehow, we don't seem to manage it really, it just seems to blow and then we just have to deal with it then, but yeah. So yeah, she definitely, she would bottle it up I think, and then it sort of erupts at some point, or she cries, I mean she cries quite easily"* (Stella, Tina's mother, 12, 374-378).

*S: "...any, like, at school, sometimes it's fine but there will be an outburst somehow when we are at home, some kind of behaviour, which is difficult..."* (Stella, 19, 605-607).

In both of the above extracts Stella referred to Tina's uncontrollable expression of emotions, when reflecting on her behaviour in emotionally challenging situations. Her reference to Tina's "*blow*" provides a strong indication of Tina's inability to contain her conflictual emotions, which in the way Stella made sense of it, is indicative of a distinctive component of the Conflicted ER Style. She referred to Tina bottling up emotions (which reflects internalisation, further

evaluated in 7.7.3.1) and “*erupting*” when she is at home, suggesting unrestrained expression after the suppression and accumulation of emotions. This, as well as, the difficulty she seems to experience in calming herself down and decreasing the negative emotions, engenders a sense of helplessness, which may be experienced by Tina, towards the externalisation of her emotions.

Danielle, Ryan’s mother, also observed this dilemma within her son:

*I: “What would be an emotionally challenging situation for him?”*

*D: “I mean they have tantrums, he, we were playing a board game the other day and (laughs) it was an activity game, and then Dad wasn't there and he was calling him because he was on his team and he was having to do these activities and he wasn't coming and then he just absolutely blew up and said he is not playing anymore and he was really enjoying it and getting hyper about it, but then because it went wrong that just enhanced the whole emotional response and he absolutely lost it.” (Danielle, 7, 215-221).*

*I: “And his behaviour really shows, he doesn't really control it?”*

*D: “He doesn't control it, no. I mean he will come down within a couple of minutes, but yeah, he is still in a rush and when it happens, he shows.” (Danielle, 8, 228-229).*

Both extracts, present Danielle’s account of her son, Ryan, being unable to control his emotions adaptively when something did not go his way, but by being rather unpredictable instead. Based on Danielle’s description, it seems as though Ryan could not contain his frustration and disappointment about the situation and, thus, displayed a more aggressive reaction. Danielle’s description of Ryan’s outburst as an unrestrained reaction (“*lost it*”) constructs a rather overly

impulsive action. Her metaphorical reference to ‘explosion’ is symbolic of this uncontrolled outburst. Although Ryan usually appears to calm down quite quickly, as Danielle’s second quotation suggested, the fact that he seems unable to contain the conflictual emotions when they occur leads to an involuntary outburst.

Overall, this sub-theme reflects the reported inability of these children to contain their conflictual emotions in challenging situations and therefore presents another distinctive component of this regulatory style. This appeared to occur when the children were unable to control the externalisation of their emotions, and as a result displayed rather uncontrolled reactions.

The three sub-themes illustrated the nuances of the aspects of the Conflicted ER Styles by presenting the reported inability in children to control/adjust a conflictual emotional state. In particular, the children’s reluctance to talk about their emotions (internalising), their struggles in regulating their overwhelming conflictual emotions, and finally their inability to contain conflictual emotions, became apparent.

*7.7.4 Master Theme (3): Focused Relational ER Style: Reported capacity to express, relate to, modulate an emotional state, and/or maintain a positive state*

In contrast to the previous master themes, the aim of the final master-theme is to illustrate, that children seemed to also present adaptive ways of dealing with socially and emotionally challenging situations and the related emotions. The distinctiveness of these regulatory styles was evident in consistent references to the children's ability, in challenging circumstances, to express their emotions, self-soothe or allow others to comfort them, minimising undesirable emotions, and/or promote and maintain a positive state, when reflecting on socially and emotionally challenging situations.

*7.7.4.1 Confident fluency in expressing emotions:*

The first sub-theme of the Focused Relational ER master-theme aims to illustrate the children's reported ability to openly express emotions rather than internalise or suppress them. For example, Luke and Michael reported the effortless in sharing their emotions with their mothers when reflecting on challenges:

*I: "Ok, mm, when you have a problem do you feel like you can speak to your mum?"*

*L: "Yeah, most of the time, yeah." (Luke, 9, 272-273).*

*I: "...and when you have a problem do you feel like you can speak to your Mum?"*

*M: "Yes (smiles) yeah."*

*I: "Yeah how do you find speaking to your mum about it?"*

*M: "It feels like I am letting out the problem and I don't need to worry about it anymore."* (Michael, 9, 251-255; 252-254 in the appendix).

In the above extracts, on reflection of being emotionally challenged, both children inferred that they would and could turn to their mothers as a source of comfort, which demonstrates their confidence in expressing their emotions. While Luke referred to *"most of the time"*, Michael described this more specifically by referring to letting out the problem and not needing *"to worry about it anymore"*. This provides a sense of freeing himself by sharing the 'burden' with his mother and highlights benefits of expressing his emotions.

Sandra, Lewis' mother, and Nicole, Luke's mother, described this distinctive component of the Focused Relational ER Style, from a different perspective, in their sons:

*S: "Last time yes we, I just say yes, I understand how you feel it is so bad and last time when we left from Kazakhstan we cried together (smiles) yes, and, mm, yes, he speaks to me, he's quite open, if something bothers him, he tells me."* (Sandra, Lewis' mother, 7, 207-209).

*N: "...he can be extraordinary mature in, like, for example, he is really, really good with little babies and kids. He adores little babies and kids. So when we are, like, at a street party and stuff he would just look after them all day and he'd be, like, really care about them and he would be completely focussed."* (Nicole, Luke's mother, 12, 397-401).

When reflecting on how their children express their emotions in certain situations, both parents' quotes present the confident fluency of their sons in expressing their emotions, in different ways. Sandra, for example, explained that her son Lewis seemed comfortable speaking about his emotions with her and to possibly seek comfort through this action. Both of these mechanisms refer to rather adaptive ER styles. This is because he does not appear to internalise the negative emotions or avoid them but, according to her, openly shares them in an attempt to find relief or contentment. Nicole, on the other hand, described her son Luke as rather effortlessly expressing his joy and care for other children. Thus, he seems able to apply a more focused relational ER style by expressing his emotions quite eloquently. Her reference to *"really care"* and *"be completely focused"* could be representative of a healthy contentment that enables him to be good around children and perhaps further mirrors a level of emotional maturity.

On the whole, this sub-theme demonstrates the reported confidence in children when it comes to expressing their emotions. This is an important theme, illustrating the fact that children seemed to prefer dealing with their emotions by talking about them or being generally confident enough to express their emotions.

#### 7.7.4.2 Capacity to regulate inhibiting emotions:

In contrast to the first sub-theme, that highlighted how participants expressed their emotions confidently, the current theme aimed to present the children's reported capacities for facing challenging emotions that resulted from socially challenging scenarios. In particular, this sub-theme reflects the children's active ability to control inhibiting emotions. The notion of control in this context is understood as a positive way of regulating constraining emotions, as it enables

children to carry on by controlling a negative state. Ryan and Michael, for example, described the capacity to regulate inhibiting emotions when reflecting on their behaviour in different social scenarios:

*I: "Ok so when you are on your own you feel nervous?"*

*P: "Yeah."*

*I: "And why is that?"*

*R: "It's just when you see big crowds and they are all listening, I've once, I can really picture this moment once when I was talking to the whole class, mm, and there was, and I could barely hear myself, I was so nervous." (Ryan, 1, 24-28).*

*I: "So what do you do when you feel so nervous?"*

*R: "Mmm (thinks), I have like a kind of trick to stop me making, getting nervous, like just looking upwards instead of looking straight in front." (Ryan, 2, 33-34).*

*I: "So what do you do?"*

*M: "Mm, sometimes if I, if I have to carry on playing, like if I go to football lessons and it, and if I do that, then I can't really go off the pitch, so I have to hide it." (Michael, 6, 144-145; 143-144 in the appendix).*

It seems evident from the above extracts that Ryan experienced anxiety prior to performances in front of a big audience, yet tried to strategically regulate the inhibiting emotions. It, thereby, appears as if his anxiety is what led to his adaptive regulation style in order to control his nervousness and enable him to perform. While Ryan referred to actively distracting himself and finding another focus, Michael simply stated that he was able to control the negative emotions



rather than running off. He recognised that he could not avoid the challenging situation and, therefore, had to find a way of dealing with it. It is as if he attempts to control the negative emotions by containing himself, in order to be able to carry on, which exemplifies a healthy way of regulating his emotions, though the emotion may still be present. Although Michael's reference to "*hiding it*" could also be interpreted as a maladaptive ER style, in this context it has advantages, as it enables him to carry on without exposing himself emotionally, or avoiding the situation.

Interestingly, Michael's mother, Linda, also described her son's ability to control inhibiting emotions in challenging situations:

*I: "What would be a socially challenging situation for Michael?"*

*L: "...recently he, he did a reading at the Easter Service in front of the whole school and I know for him that was a challenge but he, he could have said he didn't want to do it and he didn't, he took up the challenge." (Linda, Michael's mother, 12, 366-368; 387-390 in the appendix).*

*I: "Brilliant."*

*L: "But he was worried about it."*

*I: "Ah why do you think that was?"*

*L: "I think he was worried that he would get the lines wrong (...) but because he, he kind of saw a funny side of it as well it kind of defused it, but initially he was quite, quite anxious about it." (Linda, 13, 377-378; 394-400 in the appendix).*

*L: "...he had enough strength reserved to know "I've got to stand this out" (laughs)." (Linda, 14, 433-434; 459-460 in the appendix).*

There are several points of interest to be noted in the above extracts. Linda's account firstly described Michael's ability to manage his emotions in an adaptive way by demonstrating enough strength to perform despite feeling challenged. Secondly, her reference to him "*seeing the funny side of it*" implies the way in which he regulated the inhibiting emotions. Finally, her last quote quite distinctly states that despite Michael's nerves and unsettling emotions, she perceived him as capable to pull himself together and 'stand it out', again suggesting that he is able to control inhibiting emotions and thoughts to his advantage.

This resourceful way of controlling constraining emotions in a socially challenging situation was further portrayed in Sandra's account of her son Lewis:

*I: "What would be a socially challenging situation for Lewis?"*

*S: "Mmm (thinks), it's difficult, mm, because I always thought that he cannot speak out loud but in previous school it was a surprise for me that he is very sociable, but still when it is to speak out loud some, to take some role and, mm, for me I was surprised when he was in the concert, he, they gave him the first part of the play and I was, I couldn't believe that it was him so it's for me seems discovery, I don't know him fully I think." (Sandra, Lewis' mother, 5-6, 153-158).*

In this extract Sandra expressed her surprise about Lewis' confidence to take part in a school play and him being quite sociable. Her astonishment could indicate that negative emotions may have dominated Lewis' actions and feelings to a

greater degree in the past. However, the fact that he participated could be illustrative of his ability to regulate inhibiting emotions and to overcome his fear and accomplish the performance. His developed ability to adjust inhibiting emotions seems to have resulted in him speaking up and being able to perform in a school play.

On the whole, this sub-theme reflects the reported capacity in children to regulate inhibiting emotions when reflecting on socially challenging situations. This appeared to occur in children when they tried to complete a task despite the negative emotions they experienced and, therefore, found a way to control them adaptively. Taken from the children's and parents' accounts it appears that the children were able to successfully regulate their obstructing emotions, illustrating the distinctive components of this Focused Relational ER Style. Although, the negative emotion may still be present within the children, the fact that the children found a way to carry on in a challenging situation highlights the adaptive regulation style.

#### 7.7.4.3 Self-supportive minimising of undesirable emotions and/or maintenance of positive emotions:

Distinctive from the previous sub-themes, the final theme of the third master-theme, Focused Relational ER Style, reflects children's self-supportive ways to disregard or minimise negative emotions rather than controlling emotions that inhibit their performance. The concept of minimising is understood as a self-supportive way of dismissing or reducing undesirable emotions in order to maintain a positive state instead or transforming a negative emotion into a pleasant one. For example, in order to improve her emotional state, when

reflecting on a socially challenging situation that resulted in undesirable emotions, Tina explained ceasing to be nervous:

*I: "Okay so what do you usually do when you are very embarrassed or nervous?"*

*T: "I just (pauses) well I just try and make it go away."*

*I: "How?"*

*T: "Well, I try not to be nervous." (Tina, 2, 37-39).*

Richard, Mark, and Lewis described this self-supportive ER style in different ways:

*I: "Do you remember what you did in that situation, when you felt really embarrassed?"*

*R: "I (pause) emm I try to forget about it, so like try and think about something else." (Richard, 4, 107).*

*I: "And what do you do in those situations when you feel uncomfortable or embarrassed because of other people?"*

*M: "...well like if I was like reading something in front of the school and I just like made a mistake and like some people were laughing I'd just carry on just try to ignore or something. Would try and ignore others and carry on, try to stop them laughing..." (Mark, 2, 49-51).*

*I: "You try not to think about it?"*

*L: "No, mm, sometimes I think about it and, but I don't really think it as that a big problem, or I just play with my brother, cause I got other better things."*

(Lewis, 5, 118-119).

*I: "...so what would you do?"*

*L: "Never mind about it (laughs)" (Lewis, 6, 145).*

All three accounts suggest self-supportive ways in which these children seemed to disregard their negative emotions as a result of a socially or emotionally challenging situation. Richard, for example, described diffusing the challenging situation and the related emotions by thinking about something else. Similarly, Lewis explained distracting himself and minimising the negative emotions by recognising it is not 'as bad', while Mark referred to trying to ignore others that could cause these negative emotions. The described ways are quite adaptive methods of dealing with undesirable emotions. The children seemed to pursue this distinct component of the Focused Relational ER Style by dismissing or minimising the unsettling emotions in order to create a desirable emotional state instead.

Interestingly, Michael's mother, Linda, made reference to this component of the Focused Relational ER Style from a different perspective:

*"... I think with his friends, mm (thinks), he, he's quite good at pleasing his friends on, cause I think they're easier, they've got a more, like, if they're playing a game and his friend wants it to be a certain way, he'll kind of make, he's very good in not manipulating, but even with Willow he'll, he'll make that*

*other person feel like they're getting a bit of a deal out of it as well, he's quite a deal maker.*" (Linda, Michael's mother, 17, 541-546; 572-576 in the appendix).

The behaviour that Linda described on reflection of her son's behaviour could be interpreted as an advanced level of understanding other people's feelings. Her reference to "*he'll make the other person feel like they're getting a bit of a deal*" appears to suggest that her son, Michael, is able to empathise with others in a way that makes them feel they have gained something out of a situation. This, in turn, could aid the preservation of his positive state of mind.

In summary, this sub-theme reflects the reported self-supportive minimising of undesirable emotions in children. This appeared to occur when they experienced unwanted emotions, in challenging situations and managed to dismiss those feelings in adaptive ways rather than internalising them, or allowing the negative emotions to guide them for the pursue of a more desirable emotional state.

The three sub-themes, illustrate the distinctive components of the Focused Relational ER Styles by presenting the reported capacity of children to express, relate to, modulate an emotional state, and/or maintain a positive state. In particular, the children's confident fluency in expressing their emotions, their capacity to regulate inhibiting emotions (though they may still be present), and finally their self-supportive minimising of undesirable emotions to achieve and/or maintain a positive emotional state became apparent.

The following chapter will explore these results in relation to relevant theory.

### *7.8 Discussion*

Following the findings of studies one and two, which highlighted the important role of ER, the aim of the third study was to provide insight into the first-hand accounts of children and their parents, to illuminate some of the challenges and difficulties a child faces, and the ways in which they seem inclined to regulate their associated emotions. This was by exploring the children's experiences of socially and emotionally challenging situations, and their mothers' perception of their children on reflection of such situations. It was intended that the findings could shed light on further important training components for the prevention of SAD. To date, research into SAD and ER in children has been predominantly quantitative and has largely neglected the personal experiences of children. To the best of our knowledge, this study is the first to approach this topic in a qualitative way, by analysing semi-structured interviews using IPA and including parents' accounts to contribute to existing knowledge in this area. Overall, the current findings revealed three distinct ER styles that seemed to be applied in socially and emotionally challenging situations: Avoidant ER Style, Conflicted ER Style, and Focused Relational ER Style. The findings support previous studies that show the importance of preventive programmes to include and encourage more adaptive regulation strategies, which could, in turn, prevent the development and maintenance of disorders such as SAD in children.

### 7.8.1 Primary Findings

The IPA analysis resulted in the development of three distinct ER styles related to children's reflection on their experiences of socially and emotionally challenging situations, and the parental perceptions of the children's behaviour in these situations, as exemplified in the master-themes. The resulting sub-themes included children's (and parents') experiences of expression, perception, confrontation, and related behaviour towards challenging emotions. In addition, the majority of themes referred to children's anxiety around how others perceive them. They were presented with narrative accounts and citations from interview transcripts. Despite the fact that the data were interpreted by the author, the aim was to stay as close as possible to the participant's own account. The three master themes that became apparent as distinct styles of ER on reflection of socially and emotionally challenging situations were:

*'Avoidant ER Style'*, which characterised rather maladaptive ER styles that occurred prior to, or during, challenging situations. This was illustrated by the children's and their parents' description of their experiences, the children's cautiousness in disclosing emotions in response to the demanding scenarios, the way in which they perceived and faced the challenging emotions differently, and the related withdrawal or avoidant behaviour in such situations. The second theme, *'Conflicted ER Style'* illustrated the internal and external dilemmas of conflictual emotions within children and exemplified participants' experiences of applying maladaptive ER styles in response to challenging situations. This was illustrated in the unconstructive ways in which they internalised, expressed and perceived their emotions, as well as responded to them as a result of socially and emotionally provoking situations. The third theme, *'Focused Relational ER*



*Style*', showed more adaptive ways in which mothers described their children's, and children described their own fluency in emotional expressions, their capacity of regulating challenging emotions, and their ability to pursue and/or maintain a more pleasant emotional state. This was demonstrated by the way in which they perceived the challenging emotions differently, their abilities to face them, and their related focused relational behaviour in challenging scenarios.

*Avoidant ER Style – Reported avoidance as prevention of feared emotional states based on children's sensitivity to social perception*

The narrative here largely described the participants' sense that they were inclined towards avoidance tactics in certain challenging situations, seemingly to prevent the experience or the maintenance of negative emotions associated with the situation. Furthermore, the parents' experiences of children who tended towards such ER styles supported this interpretation. They reported their children coping with challenging situations by deflecting, ignoring, hiding, withdrawing, and/or quitting socially demanding situations. The reported avoidance as prevention of feared emotional states in both the children and their mothers was based on children's sensitivity to social perception and their desire to protect themselves from social scrutiny.

The sub-themes of this master-theme further highlighted the reasons why and the distinct ways in which children responded in various avoidant ER styles. They included the cautiousness in disclosing emotions, their deflection of embarrassment to avoid the exposure of any inadequacies, their apprehension in being exposed to the anxiety-provoking emotions, and their caution in modulating the feared emotional state once in the situation. Although instantly children may think that they feel better because they have protected themselves

from experiencing the anticipated negative emotions, in reality they have heightened their apprehension of certain situations. This is in line with previous research that reported avoidant ER style propensities in children when exposed to challenging situations (e.g., Brandibas, Jeunier, Clanet, & Fouraste, 2004; Leone, Ray, & Evans, 2013), as this, in turn, can lead to feelings of exclusion and social inhibitions (e.g., Beidel et al., 1999b; Fisher et al., 2004; Gazelle, & Ladd, 2003; Saavedra et al., 2010). This presents a maladaptive ER strategy, as it misleads the individual and builds, as well as maintains their anxiety (e.g., Berking et al., 2008; Mennin, 2006). Children with this thought process appear to hold a perceived apprehension and caution to repair their feelings. Consequently, they tend towards defensive, avoidance strategies, such as ignoring their feelings, being guarded, and removing themselves from situations, or avoiding them in the first place. In particular, the danger of escaping stimuli, without really eliminating them, demonstrates the maladaptive consequences in the long-term, both in terms of social relations, as well as in terms of the elevated levels of apprehension towards a situation (e.g., McManus et al., 2008; Moscovitch 2009; Plasencia et al., 2011). The maladaptive ER style of avoiding the emotions and situations, where such emotions are anticipated, can lead to the actual maintenance of negative emotions and anxiety (e.g., Wilson et al., 2011).

*Conflicted ER Style – Reported inability to control/adjust a conflictual emotional state*

Similar to existing quantitative findings, children's experience of emotion dysregulation and low emotion knowledge is highlighted within this master-theme. Based on the children's own accounts, as well as those of their parents', it appeared that children illustrated Conflicted ER Styles in the form of internalisation, suppression, and uncontrolled expression of emotions when encountering challenging situations. In particular, the internal and external struggles in children became apparent due to the conflictual emotions experienced, and their reported inability to control/adjust an overwhelming, conflictual emotional state.

The sub-themes of this master-theme detailed the experiences of children and their mothers, in terms of how they described and perceived challenging emotions, the way in which they appeared unable to face and understand emotions as a result of socially and emotionally challenging situations, and their difficulties in responding to them. The rationalisation of such propensities was based on the helplessness of children in expressing or containing their emotions, their inability to recognise and understand their emotions (low levels of emotion knowledge), as well as their inability to share and alter their emotions. This can lead children to feel vulnerable and frustrated, as they do not understand the emotions they experience and do not know how to deal with emotions that arise in, before, or during a situation. As these suppressed emotions are not eliminated, they may resurface more strongly at a later stage, resulting in uncontrolled outbursts (e.g., Flouri & Mavroveli, 2012). This, in turn, can lead to a negative state of mind, feelings of exposure and exclusion (e.g., Fisher et al., 2004;

Gazelle & Ladd 2003). It is also worth noting that the fear of humiliation and failure became apparent in the justification of these Conflicted ER styles, which underlines these negative consequences. Whilst the Conflicted ER Style connects to the first master-theme, as these avoidance styles are also based on children's sense of helplessness and sensitivity to social perception, the Avoidant ER Style differs due to the withdrawing or quitting nature of that regulatory style, particularly, as the Conflicted ER Style characterises the struggles experienced with regard to the related conflictual emotions. Children who showed tendencies towards internalisation, suppression, and uncontrolled expression of emotions usually report an increased vulnerability to negative symptoms and aggressive behaviours (e.g., Quoidbach et al., 2010; Martini, & Busseri, 2010). Correspondingly, the conflicted regulation of emotions can have unfavourable, enduring consequences, in terms of social relations as well as subjective health.

*Focused Relational ER Style – Reported capacity to express, relate to, modulate an emotional state, and/or maintain a positive state*

In contrast to the previous two master-themes, the final one illustrated participants' reports of adaptive ways of managing and adjusting negative emotions in challenging situations. Parents of these children reiterated this experience, and rationalised this in terms of their children's emotional development, resilience, maturity, and confidence. The children, on the other hand, explained the practice of this regulatory style via their desire to carry on with something and to control their anxiety, as well as their fear of embarrassment, strategically, or to simply pursue a more pleasant state. The sub-themes of this master-theme demonstrated children's confidence and fluency in

talking about emotions and more adaptive means of perceiving difficult emotions as a result of challenging scenarios, the capacity for facing such emotions, and their related solution-focused responses towards them. In particular, the experiences of both children and their parents were interpreted as the capacity to control their negative emotions in a way that enabled them to continue functioning and employ mood repair (Salovey et al., 1995), or simply minimise undesirable emotions to acquire and/or maintain a positive state. Existing literature suggests that such adaptive regulation styles can result in better academic achievements and enhanced social relations (e.g., Aldao et al., 2010; Haga et al., 2009).

The Focused Relational ER style seemed to include the recognition of emotions before, during, and after a stressful situation. It therefore incorporated a strategic process of dealing with the negative emotions and an active attempt to change them into more positive ones. The repair of emotions, once it has already emerged, appeared to reduce the negative emotions experienced and allowed the children to carry on, pick themselves up, or allow others to comfort them. This is possibly also the reason why the children tried to improve their emotional state by actively changing their thoughts to something pleasant, or minimising their undesirable emotions to acquire and/or maintain a positive state. Based on these accounts, it is as if those who apply more adaptive ER styles usually are more comfortable in expressing their emotions. They can, therefore, build a more healthy state of mind and relationships, which increases self-esteem and causes greater life satisfaction (e.g., Carthy et al., 2010; Haga et al., 2009). However, the fact that this master-theme was not represented in the participants quotes as

much as the previous two, underlines the importance of raising awareness to more adaptive regulatory styles and alternative ER options that can be employed.

Taken together, the results suggest that children in this study demonstrated tendencies towards maladaptive, as well as some adaptive, regulation styles in challenging situations based on both their own and their mother's perceptions of them. The most common ER style illustrated appeared to be Avoidant ER Style, followed by Conflicted ER Style, and Focused Relational ER. Thus, adaptive ER styles were less present in these children compared to the rather maladaptive ER styles. Interestingly, the majority of these ER styles appeared to be a result of the high sensitivity children seemed to experience towards social-perception. Consequently, this sensitivity and these profound concerns and tendencies towards more maladaptive ER could lead to increased levels of SA and, thus, negatively affect the quality of a child's life and well-being. This is in line with previous findings, suggesting emotion dysregulation to relate to SAD; as such individuals higher in SAD appear less skilled at applying adaptive ER strategies (e.g., Hermann et al., 2004; Matthew et al., 2014; Turk et al., 2005). The children's video performance in Study One of the current research, and in past research (e.g., Goldin et al., 2009b; Spokas et al., 2009; Werner & Gross) are further illustrations of this possibility. Accordingly, the study by Flouri and Mavroveli (2012) supported the appliance of reappraisal over suppression. The authors suggest that avoidance and suppression are associated with increased problem behaviour in children, whereas cognitive reappraisal was not and thus could act as a protective regulation factor. Previous studies (e.g., Hilt et al., 2010) are in agreement that there is a relationship between increased emotional and behavioural problems and maladaptive ER strategies (e.g.,

suppression, avoidance). Consequently, it is apparent that prevention and treatment programmes for children should include intensified ER education.

### *7.8.2 Limitations*

Despite the important findings of the present study, the conclusions drawn from it must be interpreted in the light of its limitations. Firstly, one could argue that the personal accounts are based on very subjective and possibly biased responses. However, this research attempted to minimise this limitation by including children's as well as parents' accounts of their offspring. Nevertheless, possible alterations in participants' memories on these experiences have to be considered. Secondly, the rather small sample from one geographic area is not representative of child populations from other areas and, thus, may not be indicative of all children's general tendencies. Notwithstanding of the fact that the methodology for this study was selected for its suitability to the research aims, in providing a rich, multifaceted, and valuable insight into children's and parents' experiences of challenging situations, it should be reiterated that, given the ideographic nature of IPA, these findings are reflective of the perspectives of a specific group of people in a specific context and are not generally applicable to the experiences of all children. Whilst other children and their parents may share similar experiences, it should be noted that these findings reflect the experiences of just nine children and their mothers. The perspective of a diverse group of adolescents from different settings may vary and add a different understanding of challenging situations and their corresponding regulatory responses. Furthermore, it is acknowledged that the use of a different set of participants (the children's mothers) is not in line with the homogenous sampling of IPA. However, a pragmatic decision was made based on the overall research

aim of determining a more in-depth comprehension of, how socially and emotionally challenging situations are experienced, by children.

As a result, the parental data offered an additional insight that the children were unable to provide, possibly due to the subtlety of the psychological experiences. The current findings, therefore, contribute to our understanding of the emotion knowledge and ER tendencies of this group of children in challenging situations, which could be translated into useful techniques, benefitting existing and future prevention and intervention programmes for disorders such as SAD in children. Lastly, the analysis endeavoured to maintain a high level of transparency and coherence, however, it is acknowledged that due to the double hermeneutic within IPA, different interpretations of the experiences may have emerged through other scholars. Despite the aims of this research being to explore the experience of the children and their parents, some researchers may have interpreted the described behaviours and reasoning in a different light, which may influence existing and future programmes in other directions. Moreover, certain areas of the data, which had been present in earlier transcripts, may have primed the researcher to certain aspects of that data. Nonetheless, it should be noted that given the prevalence within the children's and parents' accounts of the challenges faced and the responses illustrated, this possibility may have been reduced.



### 7.8.3 Strengths

Despite the limitations of the current study, there are many strengths, including the key asset of originality and contribution to existing knowledge, by assessing the personal experiences of socially and emotionally challenging situations and including children's and their parents' accounts. While the current themes, their rationalisations, and consequences are consistent with past studies (Gross & Thompson, 2009; Hofmann et al., 2012b; Mikolajczak et al., 2008; Spokas et al., 2009), the distinct ways in which children respond to challenging situations have so far not been explicitly addressed, particularly not in a qualitative way. Results from this study confirm the value of the experiential examination of relevant training components in the prevention of SAD in children. However, care must be taken that the data generated are believable and seen to generalise to the participant's world outside of this study.

The current study has provided new insights into children's experiences of challenging situations and their responses to them. The use of IPA has, thereby, facilitated the development of a rich account of the experiences, which otherwise would have been missed, with the predominance of quantitative research in this field (e.g., Nastasi & Schensul, 2005). The findings are consistent with existing research into the situations that are commonly feared by children and the challenges that are experienced in accordance with those experiences (e.g., Kashdan & Breen, 2008; Mennin & Fresco, 2009; Werner et al., 2011; Werner & Gross, 2010). The outcomes of the current study, however, contribute a greater understanding of the way in which these factors are experienced. In addition, this research has shown the internal and external processes that go on *within* children and their parents, over and above demonstrating how they

respond to, manage, and address these factors. This, in turn, has highlighted some areas where present and future programmes in the field of SA(D) and ER might be improved through further research into the children's experiences. The key findings of the current study could inform existing as well as future programmes, for example, by translating certain scenarios and experiences discussed into vignettes and role plays that children could possibly identify themselves with and practice dealing with challenging situations. This, in turn, could increase the learning factor of other alternative more adaptive ER choices.

#### *7.8.4 Interpretation of Findings and Future Directions*

The present findings addressed the adaptive ER styles that seem to be present in children and raises awareness of the maladaptive styles that they seem to get trapped in. This highlights the importance of supporting and developing more alternative and adaptive ER strategies in children. Though, the findings of the present study revealed some critical knowledge on children's behaviours in challenging situations, future studies should include children from various geographical and ethnical backgrounds and pay attention to the age range, which identifies also a shift in cognitive function whereby they get more conscious and aware of themselves. Research needs to be more sensitive to this factor, as well as the consideration of gender. In view of the previous findings, family factors and dynamics, as well as gender differences seem to play a significant role in the development of SAD and ER in children. This appears to be due to the different ways parents seemed to react to their daughters or sons (e.g., Fivush, Brotman, Buckner, & Goodman, 2000). Accordingly, Fuchs and Thelen (1988) indicated that girls expected a more sympathetic response from parents, as opposed to boys when they expressed sadness. This proposes that emotions are entertained

differently between boys and girls, and that boys may, therefore, suppress sadness more than girls. Interestingly, the current sample demonstrated the occurrence of more maladaptive ER styles in boys rather than girls, though this is likely to be due to the gender distribution of the current sample. Future research should, therefore address gender differences in more detail.

Generally, the research of negative emotion differentiation in a naturalistic context has emerged in recent years to observe how individuals essentially differentiate among emotion categories over various assessments in their daily lives (e.g., Pond et al., 2012). Future research should, therefore, include the assessment of relevant family factors and gender differences, including fathers as well as mothers in studies. It would also be of interest to focus on the empathetic intunement and modelling behaviour in children and parents. Moreover, both maladaptive styles of Avoidant and Conflicted ER seemed to be related to each other such that the conflicted state of ER strategies could possibly lead to avoidant styles. It would, therefore, also be interesting in future research to explore which ER style comes first, and which appears in concordance with the other. Finally, though previous research has differentiated negative and positive ER strategies, more recent research has shown such ER strategies, categorised as maladaptive or adaptive, depend on the context in which they are applied (e.g., Altamirano, Miyake, & Whitmer, 2010; Watkins, 2008). As such, some ER strategies that have been known, as negative or maladaptive could be advantageous under different circumstances. Similarly, other ER strategies that are described as positive or adaptive could be disadvantageous in other situations (e.g., Bonanno & Keltner, 1997; Sheppes et al., 2009). The current findings, however, presented the advantageous and

disadvantageous factors of the maladaptive and adaptive ER styles on the basis of how the situations were experienced. Future researchers should consider this in their examination of different ER styles and the prevention and intervention of SA(D).

In summary, the children of the current study appeared to be predisposed towards firstly Avoidant, secondly Conflicted, and thirdly Focused Relational ER Styles. Additionally, the rationalisations that involved concerns of failure and humiliation in front of peers and teachers, and the fewer quotes available for the Focused Relational ER Styles, stress the importance of teaching children more adaptive ER strategies, both by increasing their emotion knowledge as well as their ER skills. This is particularly important considering the fact that children high in SAD seem to be less able to apply adaptive ER approaches, which may contribute to the maintenance of SAD (e.g., Kashdan & Steger, 2006; Werner & Gross, 2010). The uncontrolled expression of emotions, or avoidance of specific activities, can be inhibiting in academic as well as social ways (e.g., Werner et al., 2011). As a result of the emerged themes of the current IPA, present and future programmes could include the experiences described by children and their parents in role-plays or vignettes and incorporate more adaptive ER substitutes. This may enable children to relate to the situations more and, in turn, enhance their learning of alternative strategies, which is in line with previous research that supported emotion-related vignettes in the development of emotion understanding (e.g., Tenenbaum et al., 2008). In addition, it is crucial to include emotion recognition skills as a basis of successful programmes, to enhance emotion knowledge and enable the learning of adaptive ER strategies (Gross, 2013; Izard et al., 2008; Troy et al., 2010). As a result, including ER stratagems,

which are aimed at increasing emotion knowledge and the healthy way of regulating emotions, could enhance the success rate of prevention and intervention programmes to reduce the risk of developing SAD and treating it more efficiently (Kashdan et al., 2011; Werner et al., 2011).

#### *7.8.5 Conclusion and Research Implications*

In order to improve treatment outcomes for SAD, it is initially necessary to acquire an enhanced understanding of underlying tendencies in children, when it comes to socially and emotionally challenging situations. This, in turn, could inform existing and future programmes and have a positive impact on treatment outcomes. The current study aimed to do this. However, instead of focusing on the consequences of elevated SA levels and emotion dysregulation, it may also be advantageous to focus on specific parenting processes, which may mediate these associations. Correspondingly, moderating or mediating variables must be taken into account, both in a quantitative as well as a qualitative approach, which could be a starting point for supplementary interventions. Additional research is warranted to determine effective strategies to predict an increase in ER and decrease or elimination of SA(D). This study is the first step towards this purpose and has enriched our understanding of children's ER tendencies, when socially and emotionally challenged, and has implications for ER skills that should be targeted in interventions.

The findings identified three distinct regulatory styles in children on reflection of such challenging situations. There was, primarily, a clear tendency to avoid or quit a situation that they experienced as socially challenging. This was in order to prevent the negative emotions associated with it to arise, to be maintained, or to avoid exposing a weak self-image. Moreover, children seemed

to tend towards suppressing or presenting struggles with controlling unsettling emotions or feeling helpless in dealing with them. Lastly, the presence of more adaptive ER styles in these children, addressed their ability to apply healthier strategies. The effects of both of the more common maladaptive ER strategies, that seemed to be employed by children in different ways, as well as the fewer presence of adaptive ER styles, stress the urgent need to provide and to teach children more alternative, adaptive ER strategies, in order to cope with challenging situations. This in turn could reduce the number of psychopathologies that have been linked with maladaptive ER or emotion dysregulation.

## Chapter Eight: General Discussion

The overall aim of the current research was to investigate the role of ER in SA in a community sample of children by employing a mixed method approach with the aim of developing a beneficial programme for the reduction of heightened levels of SA and the enhancement of ER strategies to prevent the onset of SAD. Despite the body of research in this field, many existing treatment programmes have focused on clinical samples and predominantly quantitative measures, thereby excluding the valuable, qualitative accounts of the individuals concerned (Hitchcock et al., 2009). Thus, the further aim of the current thesis was to contribute to research in this field with a more in-depth insight of the influential factors in the field of SAD and ER in children. This would further highlight the importance of CBT- and ER-based programmes, as well as, enable the refinement of existing and the development of new, efficient, prevention and intervention programmes.

The overall findings of the thesis revealed the importance of preventative CBT-based programmes that include ER strategies. Moreover, the significant findings of the current research in terms of SA and ER levels, the negative consequences of SAD (e.g., Buckner et al., 2008b; Essau & Petermann, 2001; Goldin et al., 2009a; Kashdan & Collins, 2010) and emotion dysregulation (e.g., Hermann et al., 2004; Hofmann, 2004; Matthew et al., 2014) highlight the importance of preventative social and emotional skill programmes. Despite the increase of ER levels and reduction of (S)A and behavioural difficulties levels in children of the experimental group, no causal conclusions could be made that these benefits were due to the programme, particularly because of the unexpected findings and limitations of the second study. Thus, further refinements and

further exploration of ER in children were required, which the qualitative IPA study attempted to explore. The IPA study revealed significant propensities of rather maladaptive ER styles calling for preventative and intervention programmes to be more sensitive towards certain situations and to provide children with alternative, more adaptive ER strategies.

### *8.1 Reviewing the Thesis: Limitations and Consistency*

On the critical evaluation of the contribution that the current thesis provided, it is crucial to assess the present findings within the context of the wider literature. This is in addition to the need to demonstrate an objective and reflexive evaluation between the three studies, which form the strength and consider the limitations of this research. In particular, the degree of consistency and originality demonstrated across the methodology and the findings present one of the major strengths of this thesis. Across all studies the components of the ESST-C have demonstrated to be of high importance in the reduction of (S)A and enhancement of ER levels.

Reflecting on the severe consequences and inhibitions that SA(D) and low ER have on an individual's life, as outlined in the literature review and further demonstrated in Study One, this underlines the importance of the current findings from a theoretical and practical perspective. This is encouraging in reflection of the psychological and physiological wellbeing of children from an early age. Considering the available CBT-based programmes and their successful reduction of anxiety (e.g., Barrett et al., 2006; Crawley et al., 2012; Essau et al., 2014; Flannery-Schroeder & Kendall, 2000) and SAD (e.g., Ahrens-Eipper &



Leplow, 2004; Muris et al., 2002; Masia et al., 2001; Spence et al., 2000), CBT seems a suitable approach in the treatment of SAD. However, existing studies usually utilised clinical samples limiting the generalizability of the findings to community samples. Taking into account the high prevalence rates of SAD (e.g., 29-40%, DSM-5; APA, 2013; Hammerness et al., 2008; Hitchcock et al., 2009; Kessler et al., 2005a; Knappe et al., 2011) the early onset of this disorder (e.g., 8-13 years, Dalrymple & Zimmerman, 2011; Knappe et al., 2011; Kessler et al., 2005a) as well as its severe consequences on important aspects of an individual's life (e.g., Beidel et al., 1999a; Costello et al., 2011; Fisher et al., 2004; Hudson et al., 2010; Keeley & Storch, 2009; Langley et al., 2004; Saavedra et al., 2010) the importance of more preventative programmes is emphasised. In addition, research has shown that not all individuals with SAD achieve optimum response with standard CBT packages (e.g., Compton et al., 2014). The inclusion of ER enhancement strategies has demonstrated to be useful, in view of the fact that a large amount of research has shown maladaptive ER to be an underlying factor of SAD (e.g., Erwin et al., 2003; Hermann et al., 2004; Hofmann, 2004; Mennin et al., 2009; Spokas et al., 2009). In particular, in the form of suppression, avoidance (Kashdan & Breen, 2008; Werner et al., 2011), or post-event rumination (Nolen-Hoeksema & Morrow, 1991; Clark & Wells, 1995).

It has been shown that learning to cope with negative emotions is more challenging, though more crucial, for children than learning to manage positive emotions (Cole & Hall, 2008; Ramsden & Hubbard, 2002). Moreover, the significant relationship that exists between emotion, the regulation of emotion, and SAD in children has been demonstrated. This is in line with past findings, suggesting that anxious children are more likely to apply maladaptive regulation

methods due to the absence, or scarcity, of adaptive strategies (cf. Suveg & Zeman, 2004). Furthermore, the importance of family factors that play a significant role in the development and maintenance of SAD, underline the importance of including these factors in research. These aspects, together with the predominantly quantitative approach to this matter, call for more in-depth research into this topic. The qualitative study of the current thesis is a step towards establishing important components that need to be considered in existing and future preventative programmes, with the aim of reducing levels of SA in children by enhancing their levels of ER. The development of a preventative psycho-educational programme combining CBT-based components together with social and emotion regulation enhancements skills is, therefore, promising and generated the objective of the current thesis. To our knowledge, no programme, thus far, has combined both successful factors in the prevention of SAD. Although research has argued ER components to be part of CBT (Butler et al., 2006; Fresco et al., 2013; Hollon et al., 2006), the unexpected and inconclusive findings call for further refinements in combining these mechanisms and providing more conclusive findings.

The first study demonstrated the negative consequences of high vs. low SA on some performance measures (e.g., Hofmann et al., 1997), as well as the significant relationships between SA, ER and self- and observer-ratings (e.g., Cartwright-Hatton et al., 2003). The findings highlighted the importance of specific CBT and ER components to be included in prevention programmes for SA in children (e.g., Gross et al., 2006; Gross & Munoz, 1995), as these consequences on performance and biased self-perception may contribute to the manifestation of SA and development of SAD (e.g., Beidel et al., cited in Essau

& Ollendick, 2013; Mallott, 2009). The second study, therefore aimed to examine the efficacy of the newly developed programme. The significant findings regarding the efficacy of the ESST-C in the experimental group are in agreement with previous research supporting the benefits of the combination of CBT and ER enhancement strategies (e.g., Kley et al., 2012; Smyth & Arigo, 2009) to provide children with necessary abilities to reduce the risk of developing SAD (Kashdan et al., 2011). However, as discussed previously, no causal conclusions can be made. In addition, based on the unexpected non-significant time x condition interactions, future research in this field is necessary. Furthermore, the importance of ER was presented, which required a more in-depth analysis. As a result the third study emerged in order to understand ER from the children's and parents' first-hand accounts.

The findings of the IPA study identified three distinct ER styles in children when reflecting on socially and/or emotionally challenging situations. The use of IPA facilitated the development of a rich account of the experiences, which, with the predominance of quantitative research in this field (e.g., Nastasi & Schensul, 2005), may have been missed otherwise. The findings are consistent with existing research into the situations that are commonly feared by children and the challenges that are experienced in accordance with those experiences (e.g., Kashdan & Breen, 2008; Mennin & Fresco, 2009; Werner et al., 2011; Werner & Gross, 2010). The Avoidant, Conflicted, and Focused Relational ER styles that became apparent, through the participants' first-hand accounts, highlight some areas and different ways in which present and future programmes in the field of SA(D) and ER might benefit.

Notwithstanding the significant findings of all three studies, some of the limitations (as discussed in more detail in the relevant chapters) make the findings less generalizable and conclusive. The following discusses some common limitations further and should be considered, when interpreting the findings. The literature review, for example, emphasised the importance of environmental factors, such as family and peer relations in SAD and ER (e.g., Crosby et al., 2012; Hughes & Gullone, 2007; McCoy & Raver, 2011; Scharfstein et al., 2011; Southam-Gerow, & Kendall, 2002). The present studies however, are limited to mainly mothers', and teachers' accounts. Thus, the consideration of fathers, siblings, peers, as well as family dynamics, would broaden existing knowledge on the contributing factors in SAD and ER, which, in turn, could support the development of more successful prevention programmes (e.g., Crosby et al., 2012; Bögels & Phares, 2008; Russel et al., 1998; Volling et al., 2002).

In addition, the methodological limitations of the current thesis should be considered. Both Study One and Two are limited to quantitative measures, which are known for low levels of participant self-awareness, response biases, and social desirability limitations (Paulhus, 1991). Studies that include qualitative measures such as interviews of children and parents may enhance such findings and reduce some of these limitations. It is however, crucial to recognise the supporting research about the legitimacy of self-report measures, especially considering it is the most widely applied technique for data collection in health psychology (Myers, 2000). Consistent with Watson and colleagues (2000), self-reports present a superior type of data collection when subjective emotional experiences are assessed. The insight that self-reports provide, with regard to the

attitudes, feelings, and experiences of individuals, cannot be gathered from, for example, external investigation (Guerrero, Jones, 2005).

Furthermore, the ESST-C may have had more significant findings, perhaps if the numbers in the control and experimental group were equal. The high dropout rate in the control group could have possibly been prevented if those children would have been able to participate in the programme at a later stage. Moreover, the inclusion of booster sessions may have demonstrated the maintenance of the gains of the ESST-C over time (e.g., Fisher et al., 2004; Spence & Shortt, 2007). Finally, the higher levels of (S)A, behavioural difficulties and lower levels of ER in children of the experimental group as opposed to children in the control group could have influenced the non-significant results. Consequently, the findings of the second study should be interpreted within its own limitations. However, the preventative, brief, accessible, as well as the nature of the ESST-C could also have been the reason for the significant enhancements in the experimental group. Generally, the EG revealed that levels of SA and behavioural difficulties (as per children's and parents' reports) decreased, while levels of ER increased immediately after and at three-month follow-up. Taking into account that the programme was delivered by six facilitators in different schools supports the notion that the significant findings could be due to the programme in itself. Furthermore, the significant relationship between SA(D) and ER and, thus, the importance of including ER enhancement strategies in future programmes was presented.

Most existing programmes are not grounded in scientific theory (Kotsou et al., 2011) and do not include, despite its relevance, a specific focus on adaptive ER strategies (McLaughlin & Hatzenbuehler, 2011). Furthermore, the

majority of these programmes are designed for clinical samples and are not tested empirically within a research setting (e.g., Baer et al., 2005; Gallagher et al., 2004). Consequently, Study Three aimed to address some of the key limitations and the dearth of qualitative research, which exists within the current literature, by understanding ER from children and their mothers' perspectives. The present study included children's and their mother's first-hand accounts of challenging situations with the aim of identifying and addressing the theoretical and methodological nature of current and future programmes. Although the ESST-C includes more antecedent and adaptive ER strategies, to improve children's levels of ER and maintain low levels of SA, the current study also raises awareness to certain aspects of maladaptive ER in more detail. Consequently, the findings can provide useful insights into the potential development of new prevention programmes, as well as the refinement of existing prevention programmes.

In order to obtain the best possible results of a preventative programme that includes ER enhancements strategies, it would appear to be highly relevant to investigate the experience of a community sample of children in challenging situations, which the third study aimed to do. The findings of the third study demonstrated the children's tendency towards rather maladaptive ER strategies, highlighting the necessity of future programmes to include more adaptive ER focussed factors. In addition, the presence of healthier strategies and the experiences that children and parents shared, overall, can be translated into stories and activities that could support the enhancement of more adaptive ER practices. However, the methodological limitations of IPA and the sample size in qualitative research limit the generalisation of the findings and should therefore

be considered within its limitations. As such, the findings are limited to mothers only, to one geographical area, and lastly, different questions and researchers' interpretation could have led to different results.

Finally, mixing quantitative and qualitative research has raised concerns based on the time it involves and the accuracy of understanding both methodologies in sufficient detail (cf. Yardley & Bishop, 2007). Nonetheless, once the researcher has taken this into consideration, the combination of both methodologies could indeed complement each other and improve one's understanding (Östlund et al., 2011), which this research aimed to do. In addition, taking a practical and realistic position towards mixed method research enables the use of a methodology that attempts to combine the insights provided by qualitative and quantitative studies and, thereby, enhance the communication between researchers using different methodologies as they attempt to advance knowledge (Maxcy, 2003).

Consequently, the novelty of the quantitative and qualitative study in this field and the consistent findings provide a more in-depth account of crucial factors that inform both existing and future programmes. As a result, and notwithstanding the theoretical and social impact of the current thesis, it also provides support that a short, preventative, CBT- and ER-based programme can be efficient, cost-effective, and more accessible to children. The unexpected findings of Study One concerning gaze are in line with some findings (e.g., Hofman et al., 1997) and in contrast to others (e.g., Schneier et al., 2011), which may be due to methodological difference, such as different tasks and instructions. Furthermore, this may suggest that non-clinical SA does not impact gaze in contrast to clinical SAD. The rather unexpected findings across Study Two in

terms of age and gender differences is in contrast to the current literature, which has shown that age and gender have an impact on ER (Gross & John, 2003) and SAD (Essau et al., 2012; Lock & Barrett, 2003). It has been suggested that younger compared to older children and girls versus boys express their SA and ER differently. The inconsistencies with the current study may possibly be due to the sample size and nature of the study, as most existing literature was developed from larger clinical investigations. Thus, the nature and size of the samples may have been too limited to detect broad distinctions in ER and SA propensities related to age and gender, as well as control- and experimental group differences. As a result, further exploration is warranted with larger samples, similar to the study by Gross and John (2003), or Essau and colleagues (2012), so that accurate inferences can be made.

## ***8.2 Future Research: Moving the Field Forward***

The overall findings of the current thesis demonstrated the important role of ER and the findings of the third study could aid the development of role-play and vignettes, based on the real-life experiences of children and more focused on the delivery of more advantageous ER strategies, to increase the benefits of a prevention/intervention programme. Considering the first-hand account of children and their parents on this subject, existing and future programmes could use this information in their attempt to teach children other, more advantageous ways of regulating their emotions in challenging situations. This could lead to the prevention of the development and, or, maintenance of emotion dysregulation related disorders such as SAD. The next generation of research should continue to build on the existing knowledge in ways that will contribute to the progression



in the field of SAD and ER in children, on both theoretical as well as methodological grounds, in order to help improve lives of children and their families by preventing disorders such as SAD. This unites current findings with recent research that displayed that emotion knowledge and ER can be enhanced through intensive and targeted training (e.g., Barlow et al., 2004; Bebkco et al., 2011; Calkins & Marcovitch, 2010; Kotsou et al., 2001; Mennin & Fresco, 2009). Hence, this research represents the first step in expanding the literature to investigate the benefits of such targeted interventions, and future research should explore this issue in greater depth.

Despite the promising results of the current thesis and its clear broad implications, the area of CBT-based programmes combined with ER, and ER choice in children is in its infancy. Future studies should evaluate the influence of the many additional factors that were reviewed in this thesis and are likely to have an impact on children's levels of SA(D) and ER preference. For example, the availability of cognitive resources is likely to influence children's regulatory selections, and impact on strategies like distraction that provide short-term relief but do not have long-term benefits. The consideration of children's and parents' reports, as included and interpreted in the current research, is important as it demonstrated the rather implicitly determined as well as unintentional ER tendencies. As a result, exploring how other factors affect regulatory choices in children is an important direction for future research.

The involvement of the family components that play another influential part in children's SAD, emotion knowledge, and ER, and the way in which this knowledge can be translated into more beneficial (treatment) programmes are urgently needed. Furthermore, considering the significant correlations of SA and

ER, in the previous studies of the current thesis, and given the past literature supporting the significant role healthy ER plays in the maintenance and prevention of SAD, it would be interesting to include the assessment of children's SAD levels, in order to investigate whether children with more maladaptive ER tendencies present more heightened levels of SA(D) as a result of these responses. It is important to keep in mind that adaptive ER styles existed in the children interviewed, and, thus, should be encouraged and enhanced more.

Lastly, it would be interesting to include the age and gender factor within children to enable the development of more suitable programmes for both genders and specific ages. Considering the severe consequences elevated levels of SA and low levels of adaptive ER have on everyday life the current thesis is an important step forward in highlighting the contributing factors that ought to be considered in the prevention of SAD in children. Further research on everyday anxiety and ER is needed to ensure late adolescents' successful transition into productive adult members of our society. Additional research is warranted to develop and test more successful programmes, based on the current video analysis, ESST-C, and the findings of the IPA study. The current studies have presented the important factors that play a role in SA, and revealed effective strategies that could be taught to children in order to possibly prevent psychological disorders such as SAD from developing in the first instance. Further research into other factors that contribute to children's natural development would be useful.

As the literature review has shown, an enormous amount of research has emerged over the years in the field of ER, and the meta-analysis by Aldao and colleagues (2010) summarised a majority of findings linking maladaptive

regulation strategies (e.g., rumination, suppression) and psychopathology, as well as other adaptive strategies (e.g., reappraisal, problem solving) and resilience. However, some inconsistencies have since become apparent, regarding the adaptive or maladaptive labelling of ER strategies. For example, rumination was found to also be of advantage in situations where a single goal needs to be maintained in the face of distractors (Altamirano et al., 2010). Similarly, suppression has been shown to be useful in extremely adverse situations (e.g., Bonanno & Keltner, 1997). At the same time, reappraisal and mood repair have been found to be less effective in other high intensity emotional situations (e.g., Sheppes, Catran, & Meiran, 2009; Tice & Bratslavsky, 2000). Consequently, different ER strategies seem to have different consequences depending on the contexts; healthy adaptation is the result of the ability to choose between available regulatory strategies suitable to the situations' demands (e.g., Kashdan & Rottenberg, 2010; Troy & Mauss, 2011). Accordingly, it is evident why this can be quite challenging for children, particularly considering the fact that their emotion knowledge and the different ER strategies available are still developing. Experience, support, and training will assist alongside programmes such as the current study, as well as other contributing environmental factors (e.g., Kashdan et al., 2009; O'Toole et al., 2012). Sufficient support has shown that learning to cope with negative emotions seems more difficult, though more crucial, for children, compared to learning to manage positive emotions (Cole & Hall, 2008; Ramsden & Hubbard, 2002). The inability to regulate negative emotions, in turn, may be linked to behavioural and emotional problems (e.g., Eisenberg et al., 2001a; Frick, Morris, 2004; Silk et al., 2003), and disorders such as SAD (e.g., Abbott & Rapee, 2004; Brozovich & Heimberg, 2008; Rapee & Abbott, 2007),

therefore, calling for the necessity of improving and developing more adaptive ER in children.

Considering the large amount of research evolving over the last years in the field of SAD and ER (e.g., Gross, 2013; Kerns et al., 2013; McManus et al., 2010), it has been demonstrated that many unexplored avenues remain, and that existing, as well as new programmes for the prevention or treatment of SAD and enhancement of ER are required (e.g., Hannesdottir & Ollendick, 2007; Masia-Warner et al., 2006; Neil, Christensen, 2009). Due to the heavy reliance on treatment programmes and self-report measures, this thesis encourages future research to focus on the prevention of SAD, as much as on its treatment. This will inevitably include alternative measurement techniques and methodologies to corroborate these findings. In addition, future research could compare existing training programmes based on CBT with the current training programme utilised within this research project, in order to understand which is more effective, and through the information gained in Study Three, explore which components of CBT and ER seem most beneficial. Furthermore, the information acquired throughout all three studies can be utilised in future research with alternative samples and methodological differences in order to develop beneficial programmes accordingly. Future studies could explore the impact of particular types of ER on health, and on that basis include specific strategies in (future) programmes. Additionally, the extension to other areas within and outside of the UK, would shed some light on this matter from a cultural point of view. The adoption of an increased sample size and application of more experimental, observational, and qualitative measures, could further support the generalisation of the findings. The current thesis presents the first step towards this issue.

Additional research is needed to understand how other vital circumstantial factors such as children's peers, school, and culture, impact on SA(D) and ER. This may further explain how and why adolescents tend towards particular regulation styles in socially and emotionally demanding situations. Another imperative factor that should be examined in more depth is the relationship between parenting styles and children's SAD and ER, given their high relevance in the development and maintenance of both components and their resulting significance in the field of treatment and prevention of SAD and enhancement of ER (Morris et. al., 2007). Regrettably, research on this domain, as well as other parental influences when it comes to children's levels of SAD and ER is scarce to non-existent, and more work is required to assess the environmental influences on children, such as overprotective parenting or emotionally distant parenting, that may result in maladaptive adjustments during adolescence (Morris, Steinberg, Sessa, Avenevoli, Silk, & Essex, 2002; Rubin et al., 2009).

In addition, the marital status of the parents, as well as, the relationship between grandparents and parents, has been shown to contribute to social and emotional climate of the family (Mills & Rubin, 1998; Moore et al., 2004; Morris et al., 2007). This is where, initially, children learn positive or negative ways to manage demanding situations and related emotions (e.g., Cummings & Davies, 2002) and possibly develop SAD (Hughes & Gullone, 2007; Morris et al., 2007). Consequently, future research should include the assessment of relationships within the entire family system in order to fully comprehend the interactive and additive effects on children. Caution should also be given to the ER choices in consideration of the context. Adaptive as well as maladaptive ER

strategies have shown to present both advantageous and disadvantageous based on the context in which they occur. A final consideration would be to investigate the efficacy of intervention programmes in populations that suffer from disorders other than SAD. Thus, future explorations of the success and the ease of the application of this intervention are warranted.

### *8.3 Implications of the Thesis*

The majority of available research in the field of SAD and ER has focused on the consequences of implementing different CBT and ER strategies (Essau et al., 2012; Gross, 2007; Hitchcock et al., 2009; Koole, 2009; McEvoy et al., 2012). Numerous studies have, therefore, included parents, conducted group therapy, instructed participants to engage with different ER strategies, employed self-report questionnaires, and mostly used clinical, adult samples, to examine the benefits associated with successful implementation. Despite the importance of understanding the consequences associated with various CBT-based programmes and ER strategies, research into SA and ER choices in a non-clinical child population that includes their parents' views on their behaviour could extend research in this field by highlighting and teaching children alternative, more adaptive ER strategies. The fact that all available ER options are not innate in any human, and sometimes not learned throughout the lifespan, highlights the importance of the current research. It further shows that this area requires more attention, particularly when it comes to preventing younger generations from developing ER related disorders, such as SAD. Therefore, combining the current knowledge on CBT- and ER-based treatments, as well as children's ER choices, with existing knowledge on the consequences of implementing ER styles, leads

to important conceptual extensions. Furthermore, the adaptation of a new strategy also demands overriding a default regulatory preference, which requires time and consistency to correct. Considering these findings, as well as the significant correlations of Study One and Two between SA and ER, the importance of teaching children more positive, adaptive, ER styles is emphasised. The qualitative study contributed a deeper understanding on ER in a non-clinical child population. This was of significance, as this exploratory study identified some distinct regulatory styles. This information can be useful in the refinement of existing programmes and the development of future programmes that aim to prevent SAD.

Taken together, these findings could help practitioners to identify and evaluate children's individual abilities to implement different ER strategies and to provide them with more beneficial alternatives. They would widen their emotion knowledge and ER capacity, which would enable them to deal with socially and emotionally challenging situations in a more favourable way, whilst also helping them to override their, probably inhibiting, default regulatory preference. However, comparable to the science of decision-making (e.g., Payne, Bettman, & Johnson, 1993), the ER choices are found to be based on emotional, cognitive, and motivational factors, and to some extent regulatory alternatives, depending on prior knowledge, with the consequences of implementing different strategies in different contexts. Therefore, it is necessary to teach children about emotions, increasing their emotion knowledge and, in turn, their more adaptive choice of ER, through the application to the most commonly challenging circumstances.

The requirement of flexibly adapting ER strategies to fit with diverse situational demands is central to psychological well-being (Aldao et al., 2010; Gross, 2007; Kashdan & Rottenberg, 2010), while the contrary is related to various forms of psychopathology, including SAD (Goldin et al., 2009a; Mennin et al., 2009). However, as the literature review suggested, and the current outcomes supported, the preference lies in shifting attention away from negative emotions (e.g., Joormann & Gotlib, 2008), or applying other emotion dysregulation strategies such as avoidance regulatory responses (Campbell-Sills & Barlow, 2007). As pointed out in the previous chapter, while disengagement strategies are helpful in providing short-term relief, they are maladaptive in the long run and can perpetuate anxiety and fears. This has shown to be the case for dysfunctional ER strategies that are presented by children. In other words, the cognitive factor involved in these maladaptive ER styles is highlighted and relevant for CBT-based programmes. As such, the practitioners should be mindful that children require assistance in generating alternative ways to think about unsettling events, until they can gradually build up their own social- and emotion regulation skills. Therefore, it can be expected that, with continued practice in more adaptive ER strategies, children can be helped in choosing more beneficial ER approaches more frequently, providing that their emotion knowledge has a fundamentally sound foundation, allowing it to be built upon and developed.

In sum, most socially challenging situations are connected to fears of humiliation and failure, as well as the inability to deal with the associated emotions. These factors could manifest themselves in SA(D). In order to prevent psychological disorders, which are related to emotion dysregulation, such as



SAD, CBT-based prevention programmes that include components of adaptive ER strategies are crucial. The ESST-C is the first step towards such a programme building on the findings of the first study. By teaching children necessary social- and emotion regulation skills the ESST-C provided a step towards this positive movement. To refine the programme and inform future programmes, the third study of the current thesis demonstrated the focus on emotion knowledge and ER to be fundamental. This will more easily enable children's understanding of emotions and support their ability to identify and regulate emotions more adaptively. As a result, this can reduce the risk of developing related disorders such as SAD. The current thesis is therefore a first step into this new direction through the development of a CBT- and ER-based intervention for SAD, in a non-clinical child population. It is also a demonstration of additional relevant factors crucial for the refinement of programmes such as the ESST-C and other potential programmes based on children and their parents' first-hand accounts.

Furthermore, with knowledge gained from these three studies, practitioners, parents, and teachers can identify potential areas of anxiety provoking situations, recognising and teaching children more useful ways of reducing their anxiety in social settings (e.g., Fisher et al., 2004) and also emphasising that everyday anxiety is a typical reaction to life's stressors. Furthermore, this may reduce the stigma and isolation associated with SAD. The knowledge obtained from the current thesis could therefore contribute to the early intervention of SAD in children.

#### 8.4 Conclusion

*"The greatest discovery of my generation is that human beings can alter their lives by altering their attitudes of mind."* William James (1842-1910).

This quote quite eloquently summarises that instead of mind-altering medications, individuals are able to adjust their lives by modifying the way they think and make sense of their experiences in life. As such, particularly children are on a journey of constant emotional and social development, as they encounter new experiences and stimuli. With the support of existing and constantly evolving research, the understanding of these experiences and the affiliated emotions can be enhanced, and offer children better alternatives of regulating them. This, in turn, could enhance their life satisfaction and well-being. In other words, a paradigm shift is needed, whereby a more proactive, rather than reactive, healthcare approach is employed. Consequently, an early, efficient and cost-effective preventative psycho-education programme is imperative. The results of this research provide the preliminary evidence that supports this possibility.

## References

- Abbott, M. J., & Rapee, R. M. (2004). Post-event rumination and negative self-appraisal in social phobia before and after treatment. *Journal of Abnormal Psychology, 113*(1), 136-144. DOI: 10.1037/0021-843X.113.1.136
- Acarturk, C., Smit, F., de Graaf, R., van Straten, A., ten Have, M., & Cuijpers, P. (2009). Economic costs of social phobia: A populationbased study. *Journal of Affective Disorders, 115*, 421-429. doi: 10.1016/j.jad.2008.10.008
- Adrian, M., Zeman, J., & Veits, G. (2011). Methodological implications of the affect revolution: a 35-year review of emotion regulation assessment in children. *Journal of Experimental Child Psychology, 110*(2), 171–197. doi:10.1016/j.jecp.2011.03.009
- Ahrens-Eipper S, Lepow B. (2004). *Mutig werden mit Til Tiger*. Göttingen, Hogrefe, 2004.
- Albano, P. M., Chorpita, B. F., & Barlow, D. H. (2003). Anxiety disorders. In E. J. Mash & R.A. Barkley (Eds.), *Child psychopathology* (2nd ed., pp. 279–329). New York: Guilford Press.
- Albano, A. M., & Detweiler, M. F. (2001). The development and clinical impact of social anxiety and social phobia in children and adolescents. In Stefan G. Hofmann, & Patricia Marten Di Bartolo (Eds.), *From social anxiety to social phobia: Multiple perspectives* (pp. 162–178). Needham Heights, MA: Allyn and Bacon.
- Albano, A.M., Marten P.A., Holt C.S., Heimberg R.G., Barlow D.H. (1995). Cognitive-behavioral group treatment for social phobia in adolescents. A

preliminary study. *Journal of Nervous and Mental Disorders*, 183 (10): 649–656. doi: 10.1097/00005053-199510000-00006

Aldao, A., & Nolen-Hoeksema, S. (2010). Specificity of cognitive emotion regulation strategies: A transdiagnostic examination. *Behaviour Research and Therapy*, 48, 974-983. doi:10.1016/j.brat.2010.06.002

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review*, 30, 217-237. doi:10.1016/j.cpr.2009.11.004

Alden, L. E., & Bieling, P. (1998). Interpersonal consequences of the pursuit of safety. *Behaviour Research and Therapy*, 36, 53-64. doi: 10.1016/s0005-7967(97)00072-7

Alden, L., & Cappe, R. (1988). Characteristics predicting social functioning and treatment response in clients impaired by extreme shyness: Age of onset and the public/private shyness distinction. *Canadian Journal of Behavioural Science*, 20(1), 40-49. <http://dx.doi.org/10.1037/h0079919>

Alden, L. E., Mellings, T. M. B., & Ryder, A. G. (2001). Social anxiety, social phobia, and the self. In S. G. Hofmann & P. M. DiBartolo (Eds.), *From social anxiety to social phobia: Multiple perspectives*. Needham Heights, MA, US: Allyn & Bacon.

Alden, L. E., & Taylor, C. T. (2004). Interpersonal processes in social phobia. *Clinical Psychology Review*, 24, 857-882. doi:10.1016/j.cpr.2004.07.006

- Alden, L. E., & Wallace, S. T. (1995). Social phobia and social appraisal in successful and unsuccessful social interactions. *Behaviour Research and Therapy*, 33, 497–505. doi:10.1016/0005-7967(94)00088-2
- Alfano, C. A., Beidel, D. C., & Turner, S. M. (2006). Cognitive correlates of social phobia among children and adolescents. *Journal of Abnormal Child Psychology*, 34(2), 189-201. doi: 10.1007/s10802-005-9012-9
- Alloy, L. B., Abramson, L. Y., Whitehouse, W. G., Hogen, M. E., Panzarella, C., & Rose, D. T. (2006). Prospective incidence of first onsets and recurrences of depression in individuals at high and low cognitive risk for depression. *Journal of Abnormal Psychology*, 115 (1),145-156. doi:10.1037/0021-843X.115.1.145
- Altamirano, L. J., Miyake, A., & Whitmer, A. J. (2010). When mental flexibility facilitates cognitive control: Beneficial side effects of ruminative tendencies on goal maintenance. *Psychological Science*, 21, 1377–1382. doi: 10.1177/0956797610381505
- Altheide, D. L. & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In: Denzin, N. K.& Lincoln, Y. S. (eds), *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications, pp. 485–499.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, text revision (4th ed.)*. Washington, DC: APA.

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: American Psychiatric Publishing.
- Amin, N., Foa, E. B., & Coles, M. E. (1998). Negative interpretation bias in social phobia. *Behaviour Research and Therapy*, 36, 945– 957.  
doi:10.1016/S0005-7967(98)00060-6
- Amstadter, A. (2008). Emotion regulation and anxiety disorders. *Journal of Anxiety Disorders*, 22, 211-221. doi:10.1016/j.janxdis.2007.02.004
- Anderson, B., Goldin, P. R., Kurita, K., & Gross, J. J. (2008). Self-representation in social anxiety disorder: linguistic analysis of autobiographical narratives. *Behaviour Research and Therapy*, 46, 1119-1125.  
doi:10.1016/j.brat.2008.07.001
- Andrews, G., Creamer, M., Crino, R., Hunt, C., Lampe, L., & Page, A. (2003). *The treatment of anxiety disorders: Clinician guides and patient manuals* (2nd ed.). Cambridge: Cambridge University Press.
- Anticich, S. A. J., Barrett, P. M., Silverman, W., Lacherez, P., & Gillies, R. (2013). The prevention of childhood anxiety and promotion of resilience among preschool-aged children: a universal school based trial. *Advances in School Mental Health Promotion*, 6:2, 93-121.  
doi:10.1080/1754730X.2013.784616
- Arnold, P., Banerjee, P., Bhandari, R., Lorch, E., Ivey, J., Rose, M., Rosenberg, D. R. (2003). Childhood anxiety disorders and developmental issues in

anxiety. *Current Psychiatry Reports*, 5, 252–265.

<http://dx.doi.org/10.1007/s11920-003-0054-9>

Asher, S. R., & Wheeler, V. A. (1985). Children's loneliness: A comparison of rejected and neglected peer status. *Journal of Consulting and Clinical Psychology*, 53, 500–505. <http://dx.doi.org/10.1037/0022-006X.53.4.500>

Ashworth, P. (2003). *Conceptual Foundations of Qualitative Psychology*. In Smith, J.A., editor (2008), *Qualitative psychology: a practical guide to methods*. Sage.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10, 125–143. doi: 10.1093/clipsy/bpg015

Baer, S., & Garland, J. (2005). Pilot study of community-based cognitive behavioral group therapy for adolescents with social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 258–264. <http://dx.doi.org/10.1097/00004583-200503000-00010>

Baker, S. R., & Edelmann, R. J. (2002). Is social phobia related to lack of social skills? Duration of skill-related behaviours and ratings of behavioural adequacy. *British Journal of Clinical Psychology*, 41, 243–257. doi: 10.1348/014466502760379118

Band, E. B., & Weisz, J. R. (1988). How to feel better when it feels bad: children's perspectives on coping with everyday stress. *Developmental Psychology*, 24 (2), 247–253. doi:10.1037/0012-1649.24.2.247

- Banerjee, R., & Henderson, L. (2001). Social–cognitive factors in childhood social anxiety: A preliminary investigation. *Social Development, 10*(4), 558–572. doi: 10.1111/1467-9507.00180
- Banerjee, R., & Watling, D. (2010). Self-presentational features in childhood social anxiety. *Journal of Anxiety Disorders, 24*(1), 34–41.  
doi:10.1016/j.janxdis.2009.08.004
- Banister, P., Burman, E., Parker, I., Taylor, M. & Tindall, C. (2003). *Qualitative methods in psychology: A research guide*. Maidenhead: Open University Press.
- Bar-Haim, Y., Lamy, D., Pergamin, L., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2007). Threat-related attentional bias in anxious and nonanxious individuals: A meta-analytic study. *Psychological Bulletin, 133*, 1–24. doi: 10.1037/0033-2909.133.1.1
- Bariola, E., Gullone, E., Hughes, E.K. (2011). Child and adolescent emotion regulation: the role of parental emotion regulation and expression. *Clinical Child Family Psychology Rev, 14*, 198–212. doi 10.1007/s10567-011-0092-5
- Barker, C., Pistrang, N. & Elliott, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. 2<sup>nd</sup> edn. Wiley, Chichester.
- Barkham, M. (2003). Quantitative research on psychotherapeutic interventions: Methods and findings across four research generations. In Woolfe, R.,



- Dryden, W. & Strawbridge, S. (Ed.), *Handbook of Counselling Psychology* (pp. 25-73). London: Sage.
- Baron-Cohen S. (2002). The extreme male brain theory of autism. *Trends in Cognitive Sciences*; 6, 248– 254. doi:10.1016/S1364-6613(02)01904-6
- Baron-Cohen, S., Leslie, A. M., & Frith, U. (1985). Does the autistic child have a “theory of mind”? *Cognition*, 21(1), 37-46. doi:10.1016/0010-0277(85)90022-8
- Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behaviour Research and Therapy*, 35, 205-230. doi:10.1016/S0005-7894(04)80036-4
- Barrett, P. M. (1998). Evaluation of cognitive-behavioral treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 24, 459-468. doi: 10.1207/s15374424jccp2704\_10
- Barrett, P.M. (2004). *FRIENDS for life: Group leaders' manual*. Brisbane, Australia: Australian Academic Press.
- Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996a). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology*, 64, 333–342. doi:10.1037/0022-006X.64.2.333
- Barrett, P. M., Dadds, M. R., Rapee, R. M., & Ryan, S. M. (1996b). Family enhancement of cognitive style in anxious and aggressive children. *Journal of Abnormal Child Psychology*, 24, 187–203. doi:10.1007/BF01441484

- Barrett, P. M., Duffy, A. L., Dadds, M. R., & Rapee, R. M. (2001a). Cognitive-behavioral treatment of anxiety disorders in children: Long-term (6-year) follow-up. *Journal of Consulting and Clinical Psychology, 69*, 135–141. doi: 10.1037//0022-006X.69.1.135
- Barrett, L., Gross, J. J., Christensen, T. C., & Benvenuto, M. (2001b). Knowing what you're feeling and knowing what to do about it: Mapping the relation between emotion differentiation and emotion regulation. *Cognition and Emotion, 15*, 713-724. doi:10.1080/02699930143000239
- Barrett, P. M., Lock, S., & Farrell, L. J. (2005). Developmental differences in universal preventive intervention for child anxiety. *Clinical Child Psychology and Psychiatry, 10*, 539–555. doi: 10.1177/1359104505056317
- Barrett, P. M., Farrell, L. J., Ollendick, T. H., & Dadds, M. (2006). Longterm outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: an evaluation of the friends program. *Journal of Clinical Child & Adolescent Psychology, 35*(3), 403–411. doi:10.1207/s15374424jccp3503\_5
- Barrett, P. M., Lowry-Webster, H., & Turner, C. (2000b). *FRIENDS program for children: Group leaders manual*. Brisbane: Australian Academic Press.
- Barrett, P. M., & Pahl, K.M. (2006). School-based intervention: Examining a universal approach to anxiety management. *Australian Journal of Guidance and Counselling, 16*(1), 55–75. <http://dx.doi.org/10.1375/ajgc.16.1.55>

- Barrett, P.M., & Turner, C.M. (2001). Prevention of anxiety symptoms in primary school children: Preliminary results from a universal school-based trial. *British Journal of Clinical Psychology*, 40, 399-410.  
doi: 10.1348/014466501163887
- Barrett, P. M., & Turner, C. M. (2004). Prevention strategies. In T. L. Morris, & J. S. March (Eds.), *Anxiety disorders in children and adolescents* (pp. 371–386)., 2nd ed. New York: The Guilford Press.
- Baumeister, H., & Harter, M. (2007). Prevalence of mental disorders based on general population surveys. *Social Psychiatry and Psychiatric Epidemiology*, 42(7), 537-546. doi 10.1007/s00127-007-0204-1
- Beatty, M. J., Heisel, A. D., Hall, A. E., Levine, T. R., & La France, B. H. (2002). What can we learn from the study of twins about genetic and environmental influences on interpersonal affiliation, aggressiveness, and social anxiety?: A meta-analytic study. *Communication Monographs*, 69(1), 1–18. doi: 10.1080/03637750216534
- Bebko, G. M., Franconeri, S. L., Ochsner, K. N., Chiao, J. Y. (2011). Look before you regulate: Differential perceptual strategies underlying expressive suppression and cognitive reappraisal. *Emotion*, 11(4), 732-742.  
doi: 10.1037/a0024009
- Beck, A.T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

- Beck, A. T., & Dozios, D. J. A. (2011). Cognitive therapy: current status and future directions. *Annual Review of Medicine*, 62,397-409.  
doi: 10.1146/annurev-med-052209-100032
- Beidas, R. S., Mychailyszyn, M. P., Podell, J. L., & Kendall, P. C. (2013). Brief Cognitive-Behavioral Therapy for Anxious Youth: The Inner Workings. *Cognitive and Behavioral Practice*, 20(2), 134–146.  
doi:10.1016/j.cbpra.2012.07.004
- Beidel, D. C., Alfano, C. A., Kofler, M. J., Rao, P. A., Scharfstein, L., and Wong Sarver, N. (2014). The Impact of Social Skills Training For Social Anxiety Disorder: A Randomized Controlled Trial. *Journal of Anxiety Disorders* 28, 908-918. doi:10.1016/j.janxdis.2014.09.016
- Beidel, D.C., & Turner, S.M. (1997). At risk for anxiety: Psychopathology in the offspring of anxious parents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 918–924.  
<http://dx.doi.org/10.1097/00004583-199707000-00013>
- Beidel, D. C., & Turner, S. M. (1998). *Shy children, phobic adults: The nature and treatment of social phobia*. Washington, DC: American Psychological Association.
- Beidel, D. C., & Turner, S. M. (2007). *Shy children, phobic adults: Nature and treatment of social phobia* 2<sup>nd</sup> edition. Washington, D. C.: American Psychological Association.

- Beidel, D. C., Turner, S. M., & Dancu, D. V. (1985). Physiological, cognitive and behavioral aspects of social anxiety. *Behaviour Research and Therapy*, 23(2), 109–117. doi:10.1016/0005-7967(85)90019-1
- Beidel, D. C., Turner, S. M., Hamlin, K., & Morris, T. L. (2000). The Social Phobia and Anxiety Inventory for Children (SPAI-C): External and discriminative validity. *Behavior Therapy*, 31, 75–87. doi:10.1016/S0005-7894(00)80005-2
- Beidel, D. C., Turner, S. M., & Morris, T. L. (1995). A new inventory to assess childhood social anxiety and phobia: The social phobia and anxiety inventory for children. *Psychological Assessment*, 7, 73-79. doi:10.1037/1040-3590.7.1.73
- Beidel D. C., Turner S. M., Morris T. (1999a). Psychopathology of childhood social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38:643–50.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology*, 68(6), 1072–1080. doi:10.1037/0022-006X.68.6.1072
- Beidel, D. C., Turner, S. M., & Taylor-Ferreira, J. C. (1999b). Teaching study-skills and test-taking strategies to elementary school children: The Testbusters program. *Behavior Modification*, 23, 630-646. doi: 10.1177/0145445599234007

- Beidel, D. C., Turner, S. M., Young, B., & Paulson, A. (2005). Social effectiveness training for children: Three-year follow-up. *Journal of Consulting and Clinical Psychology, 73*, 721–725. doi: 10.1037/0022-006X.73.4.721
- Bell-Dolan, D. J., Foster, S. L., & Smith C., J. (1995). Girls' peer relations and internalizing problems: Are socially neglected, rejected, and withdrawn girls at risk? *Journal of Clinical Child Psychology, 24*, 463–473. doi: 10.1207/s15374424jccp2404\_10
- Bender, P. K., Reinholdt-Dunne, M. L., Esbjørn, B. H., & Pons, F. (2012). Emotion dysregulation and anxiety in children and adolescents: Gender differences. *Personality and Individual Differences, 53*(3), 284–288. doi:10.1016/j.paid.2012.03.027
- Benjamin, R. S., Costello, E. J., & Warren, M. (1990). Anxiety disorders in a pediatric sample. *Journal of Anxiety Disorders, 4*(4), 293-316. doi:10.1016/0887-6185(90)90027-7
- Bennett, M. & Gillingham, K. (1991). The role of self-focused attention in children's attributions of social and emotions to the self. *Journal of Genetic Psychology 152*: 303-309. doi: 10.1080/00221325.1991.9914688
- Berger, P. L. & Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Garden City, NY: Doubleday.

- Berking, M. & von Känel, M. (2007). Mindfulness training as a psychotherapeutic tool: Clarification of concept, clinical application and current state of empirical research. *Psychotherapie Psychosomatik Medizinische Psychologie*, 57, 170-177. doi: 10.1055/s-2006-951956
- Berking, M., Wupperman, P., Reichardt, A., Pejic, T, Dippel, A., Znoj, H. (2008). Emotion-regulation skills as a treatment target in psychotherapy. *Behaviour Research and Therapy*, 46, 1230-1237. doi: 10.1016/j.brat.2008.08.005
- Berstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals*. Westport, CT: Praeger.
- Bernstein D.A., Borkovec T.D. (1973): *Progressive Relaxation Training: A Manual for the Helping Professions*. Champaign, IL: Research Press.
- Bernstein, G.A. (1991). Comorbidity and severity of anxiety and depressive disorders in a clinic sample. *Journal of American Academic Child Adolescent Psychiatry* 30:43–50. <http://dx.doi.org/10.1097/00004583-199101000-00007>
- Biesecker, G. E., & Easterbrooks, M. A. (2001). *Emotion Regulation Checklist for Adolescents. Adapted from Shields, A.M. & Cicchetti, D (1997)*. Unpublished manuscript, Tufts University.
- Biesta, G. J. J., & Burbules, N. C. (2003). *Pragmatism and educational research*. Lanham, MD: Rowman and Littlefield.

- Biggerstaff, D., & Thompson, A. R. (2008). Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology*, 5(3), 214–224. doi: 10.1080/14780880802314304
- Blakemore, S. J., Burnett, S., & Dahl, R. E. (2010). The role of puberty in the developing adolescent brain. *Human Brain Mapping*, 31(6), 926–933. doi: 10.1002/hbm.21052.
- Blöte, A. W., Kint, M. J., & Westenberg, P. M. (2007). Peer behavior toward socially anxious adolescents: classroom observations. *Behaviour Research and Therapy*, 45(11), 2773–2779. doi:10.1016/j.brat.2007.06.011
- Boden, M. T., & Berenbaum, H. (2012). Facets on emotional clarity and suspiciousness. *Personality and Individual Differences*, 53, 426–430. doi:10.1016/j.paid.2012.04.010
- Boden, M. T., John, O. P., Goldin, P. R., Werner, K., Heimberg, R. G., & Gross, J. J. (2012). The role of maladaptive beliefs in cognitive-behavioral therapy: Evidence from social anxiety disorder. *Behaviour research and therapy*, 50(5), 287–291. doi:10.1016/j.brat.2012.02.007
- Bögels, S. M., & Brechman-Toussaint, M. L. (2006). Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs. *Clinical Psychology Review*, 26(7), 834–856. doi:10.1016/j.cpr.2005.08.001



- Bögels, S. M., & Mansell, W. (2004). Attention processes in the maintenance and treatment of social phobia: hypervigilance, avoidance and self-focused attention. *Clinical Psychology Review*, 24(7),827-856.  
doi:10.1016/j.cpr.2004.06.005
- Bögels, S. M., Phares, V. (2008). Fathers' role in the etiology, prevention and treatment of child anxiety: A review and new model. *Clinical Psychology Review* 28, 539–558. doi:10.1016/j.cpr.2007.07.011
- Bögels, S.M., Rijseumus, W., De Jong, P.J., (2002). Self-focused attention and social anxiety: the effects of experimentally heightened self-awareness on fear, blushing, cognitions, and social skills. *Cognitive Therapy and Research* 26, 461–472. doi: 10.1023/A:1016275700203
- Bögels, S. M., van Dongen, L., & Muris, P. (2003). Family influences on dysfunctional thinking in anxious children. *Infant and Child Development*, 12, 243–252. doi: 10.1002/icd.288
- Bögels, S. M., Van Oosten, A., Muris, P., & Smulders, D. (2001). Familial correlates of social anxiety in children and adolescents. *Behaviour Research and Therapy* 39(3): 273-287. doi:10.1016/S0005-7967(00)00005-X
- Bögels, S. M., & Zigterman, D. (2000). Dysfunctional cognitions in children with social phobia, separation anxiety and generalized anxiety disorder. *Journal of Abnormal Child Psychology*, 28, 205-211. doi: 10.1023/A:1005179032470

- Bohnert, A. M., Crnic, K. A., & Lim, K. G. (2003). Emotional competence and aggressive behaviour in school-age children. *Journal of Abnormal Child Psychology*, 31, 79-91. doi: 10.1023/A:1021725400321
- Bonanno, G.A., & Keltner, D. (1997). Facial expressions of emotion and the course of conjugal bereavement. *Journal of Abnormal Psychology*, 106, 126-137. doi:10.1037/0021-843X.106.1.126
- Bonanno, G. A., Papa, A., Lalande, K., Westphal, M., & Coifman, K. (2004). The importance of being flexible. The ability to both enhance and suppress emotional expression predicts long-term adjustment. *Psychological Science*, 15, 482–487. doi: 10.1111/j.0956-7976.2004.00705.x
- Boni, L. C., Brown, R. T., Davis P. C. , Hsu L., Hopkins K. (2001). Social information processing and magnetic resonance imaging in children with sickle cell disease. *Journal of Paediatric Psychology*; 26, 309–319. doi: 10.1093/jpepsy/26.5.309
- Booth-LaForce, C., Oxford, M. L. (2008). Trajectories of social withdrawal from Grades 1 to 6: Prediction from early parenting, attachment, and temperament. *Developmental Psychology*, 4, 1298–1313. doi:10.1037/a0012954
- Borkovec, T. D., Newman, M. G., Pincus, A. L., & Lytle, R. (2002). A component analysis of cognitive behavioral therapy for generalized anxiety disorder and the role of interpersonal problems. *Journal of Consulting and Clinical Psychology*, 70, 288–298. doi:10.1037/0022-006X.70.2.288

- Bower, G. H. (1981). Mood and memory. *American Psychologist*, 36, 129-148.  
<http://dx.doi.org/10.1037/0003-066X.36.2.129>
- Boyum, L. A., & Parke, R. D. (1995). The role of family emotional expressiveness in the development of children's social competence. *Journal of Marriage and the Family*, 57(3), 593–608.  
<http://dx.doi.org/10.2307/353915>
- Bradley, S. (2000). *Affect regulation and the development of psychopathology*. New York: Guilford.
- Brandibas, G., Jeunier, B., Clanet, C., & Fouraste, R. (2004). Truancy, school refusal and anxiety. *School Psychology International*, 25, 117-126. doi: 10.1177/0143034304036299
- Braun, V. & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, (2), 77-101.  
<http://dx.doi.org/10.1191/1478088706qp063oa>
- Breinholst, S., Esbjørn, B. H., Reinholdt-Dunne, M. L., & Stallard, P. (2011). CBT for the treatment of child anxiety disorders: a review of why parental involvement has not enhanced outcomes. *Journal of Anxiety Disorders*. 26(3):416-24. doi:10.1016/j.janxdis.2011.12.014
- Brewer, J., & Hunter, A. (1989). *Multimethod research: A synthesis of styles*. Newbury Park, CA: Sage.
- Brinthaup, T. M., Hein, M. B., & Kramer, T. E. (2009). The self-talk scale: Development, factor analysis, and validation. *Journal of Personality Assessment*, 91, 82-92. <http://dx.doi.org/10.1080/00223890802484498>

- Brocki, J. J. M., Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21, (1), 87 - 108. doi: 10.1080/14768320500230185
- Broderick, P. C., & Korteland, C. (2004). A prospective study of rumination and depression in early adolescence. *Journal of Clinical Child and Adolescent Psychology*, 9, 383-394. doi: 10.1177/1359104504043920
- Brook, C. A., & Schmidt, L. A. (2008). Social anxiety disorder: a review of environmental risk factors. *Neuropsychiatric Disease and Treatment*, 4(1), 123–143. <http://dx.doi.org/10.2147/NDT.S1799>
- Brown, J. R., & Dunn, J. (1996). Continuities in emotion understanding from three to six years. *Child Development*, 67, 789–802. doi:10.2307/1131861
- Brozovich, F., & Heimberg, R. G. (2008). An analysis of post-event processing in social anxiety disorder. *Clinical Psychology Review*, 28(6), 891-903. doi: 10.1016/j.cpr.2008.01.002
- Brozovich, F.A., & Heimberg, R.G. (2011). A treatment refractory case of social anxiety disorder: Lessons learned from a failed course of cognitive-behavioral therapy. *Cognitive and Behavioral Practice*, 18, 316–325. doi: 10.1016/j.cbpra.2010.07.003

- Bruce, S. E., Yonkers, K. A., Otto, M. W., Eisen, J. L., Weisberg, R. B., Pagano, M., Shea, M. T., & Keller, M. B. (2005). Influence of Psychiatric Comorbidity on Recovery and Recurrence in Generalized Anxiety Disorder, Social Phobia, and Panic Disorder: A 12- Year Prospective Study. *American Journal of Psychiatry*, 162, 1179-1187. doi: 10.1176/appi.ajp.162.6.1179
- Bruch, M. A., Fallon, M., & Heimberg, R. G. (2003). Social phobia and difficulties in occupational adjustment. *Journal of Counseling Psychology*, 50(1), 109- 117. doi:10.1037/0022-0167.50.1.109
- Bruch, M. A., & Heimberg, R. G. (1994). Differences in perceptions of parental and personal characteristics between generalized and non-generalized social phobics. *Journal of Anxiety Disorders*, 8, 155–168. [http://dx.doi.org/10.1016/0887-6185\(94\)90013-2](http://dx.doi.org/10.1016/0887-6185(94)90013-2)
- Brüne M. (2005). Emotion recognition, ‘theory of mind,’ and social behaviour in schizophrenia. *Psychiatry Research*; 133, 135–147. doi:10.1016/j.psychres.2004.10.007
- Bryman, A. (1988). *Quality and quantity in social research*. London: Unwin Hyman.
- Buckner, J.D., Ecker, A.H., & Proctor, S.L. (2011). Social anxiety and alcohol problems: The roles of perceived descriptive and injunctive peer norms. *Journal of Anxiety Disorders*, 25, 631-638. doi:10.1016/j.janxdis.2011.02.003

- Buckner, J. D., Maner, J. K., & Schmidt, N. B. (2008a). Difficulty disengaging attention from social threat in social anxiety. *Cognitive Therapy and Research*, 34, 99-105. doi 10.1007/s10608-008-9205-y
- Buckner J.D., Schmidt, N.B., Lang, A.R., Small, J., Schlauch, R.C., Lewinsohn P.M. (2008b). Specificity of social anxiety disorder as a risk factor for alcohol and cannabis dependence. *Journal of Psychiatric Research*; 42: 230–239. doi:10.1016/j.jpsychires.2007.01.002
- Burman, E. (1994). *Deconstructing Developmental Psychology*. London: Routledge.
- Burnard P. (1996). Teaching the analysis of textual data: an experiential approach. *Nurse Education Today* 16, 278–281. doi:10.1016/S0260-6917(96)80115-8
- Burns, D. (1989). *The feeling good handbook*. New York: William Morrow and Company, Inc.
- Burstein, M., He, J. P., Kattan, G., Albano, A. M., Avenevoli, S., & Merikangas, K. R. (2011). Social phobia and subtypes in the National Comorbidity Survey- Adolescent Supplement: Prevalence, correlates, and comorbidity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(9), 870-880. doi: 10.1016/j.jaac.2011.06.005
- Burton, M., Schmertz, S. K., Price, M., Masuda, A., & Anderson, P. L. (2013). The relation between mindfulness and fear of negative evaluation over the course of cognitive behavioral therapy for social anxiety disorder. *Journal of Clinical Psychology*, 69(3), 222–228. doi: 10.1002/jclp.21929

- Burwell, R. A., & Shirk, S. R. (2007). Subtypes of rumination in adolescence: associations between brooding, reflection, depressive symptoms, and coping. *Journal of Clinical Child and Adolescent Psychology, 36*, 56-65. doi: 10.1080/15374410709336568
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review, 26*(1), 17–31. doi:10.1016/j.cpr.2005.07.003
- Butler, E. A., Egloff, B., Wilhelm, F. H., Smith, N. C., Erickson, E. A., & Gross, J. J. (2003). The social consequences of expressive suppression. *Emotion, 3*(1), 48-67. <http://dx.doi.org/10.1037/1528-3542.3.1.48>
- Butler, E. A., Lee, T. L., & Gross, J. J. (2007). Emotion regulation and culture: Are the social consequences of emotional suppression culture-specific? *Emotion, 7*(1), 30-48. doi:10.1037/1528-3542.7.1.30
- Cacioppo, J. T., & Gardner, W. L. (1999). Emotion. *Annual Review of Psychology, 50*, 191–214. doi: 10.1146/annurev.psych.50.1.191
- Calkins, S. D., Keane, S. P. (2009). Developmental origins of early antisocial behavior. *Developmental Psychopathology, 21*(4), 1095–1109. doi:10.1017/S095457940999006X
- Calkins, S. D., & Marcovitch, S. (2010). Emotion regulation and executive functioning in early development: Integrated mechanisms of control supporting adaptive functioning. In S. D. Calkins & M. A. Bell (Eds.),

- Child Development at the intersection of emotion and Cognition* (pp. 37-58). Washington, DC: American Psychological Association.
- Calvete, E., & Cardenoso, O. (2002). Self-talk in adolescents: Dimensions, states of mind, and psychological maladjustment. *Cognitive Therapy and Research*, 26(4), 473–485. doi: 10.1023/A:1016227817041
- Campbell-Sills, L., & Barlow, D. H. (2007). Incorporating emotion regulation into conceptualizations and treatments of anxiety and mood disorders. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 542–559). New York: Guilford.
- Campos, J. J., Campos, R. G., & Barrett, K. C. (1989). Emergent themes in the study of emotional development and emotion regulation. *Developmental Psychology*, 25, 394–402. doi:10.1037/0012-1649.25.3.394
- Campos, J. J., Walle, E. A., Dahl, A., & Main, A. (2011). Reconceptualizing emotion regulation. *Emotion Review*, 3, 26–35.  
doi: 10.1177/1754073910380975
- Caracelli, V. J. & Riggan, L. J. C. (1994). Mixed-method evaluation: Developing quality criteria through concept mapping. *Evaluation Practice*, 15, 139–152. doi: 10.1177/109821409401500204
- Carey, J. W. (1993). Linking qualitative and quantitative methods: Integrating cultural factors into public health. *Qualitative Health Research*, 3, 298–318. doi: 10.1177/104973239300300303
- Carducci, B. J., & Zimbardo, P. G. (1995). Are you shy? *Psychology Today*, 28, 34 – 40, 64, 66, 68, 70, 78, 82.



- Carthy, T., Horesh, N., Apter, A., & Gross, J. J. (2010). Patterns of emotional reactivity and regulation in children with anxiety disorders. *Journal of Psychopathology and Behavioral Assessment*, 32(1), 23–36. doi 10.1007/s10862-009-9167-8
- Cartwright-Hatton, S., Hodges, L., & Porter, J. (2003). Social anxiety in childhood: the relationship with self and observer rated social skills. *Journal of Child Psychology and Psychiatry*, 44, 737-742. doi: 10.1111/1469-7610.00159
- Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review*, 26(7), 817-833. doi:10.1016/j.cpr.2005.12.002
- Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C., & Harrington, R. (2004). Systematic review of the efficacy of cognitive behaviour therapies for childhood and adolescent anxiety disorders. *The British Journal of Clinical Psychology*, 43,421–436. doi: 10.1348/0144665042388928
- Cartwright-Hatton, S., Tschernitz, N., & Gomersall, H. (2005). Social anxiety in children: social skills deficit, or cognitive distortion? *Behaviour Research and Therapy*, 43,131-141. doi:10.1016/j.brat.2003.12.003
- Carver, C. S., & Scheier, M. J. (1978). The self-focusing effects of dispositional self-consciousness, mirror presence, and audience presence. *Journal of*

*Personality and Social Psychology*, 36, 324– 332. doi: 10.1037/0022-3514.36.3.324

Casey, R. J. (1996). Emotional competence in children with externalizing and internalizing disorders. In M. Lewis & M. W. Sullivan (Eds.), *Emotional development in atypical children* (pp. 161–184). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Cassidy, J. (1994). Emotion regulation: influences on attachment relationships. *Monographs of the Society for Research in Child Development*, 59, 228–249. doi: 10.1111/j.1540-5834.1994.tb01287.x

Caster, J. B., Inderbitzen, H. M., & Hope, D. (1999). Relationship between youth and parent perceptions of family environment and social anxiety. *Journal of Anxiety Disorders*, 13, 237–251. doi:10.1016/S0887-6185(99)00002-X

Chambless, D. L., & Hope, D. A. (1996). Cognitive approaches to the psychopathology and treatment of social phobia. In: P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 345–382). New York: Guilford Press.

Chaplin, T. M. (2006). Anger, happiness, and sadness: Associations with depressive symptoms in late adolescence. *Journal of Youth and Adolescence*, 35, 977–986. doi: 10.1007/s10964-006-9033-x

Chaplin, T., Cole, P. M., Zahn-Waxler, C. (2005). Parental socialization of emotional expression: gender differences and relations to child adjustment. *Emotion* 5, 80–88. doi:10.1037/1528-3542.5.1.80

- Chapman, E., & Smith, J. A. (2002). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology*, 7(2), 125–130.  
doi: 10.1177/1359105302007002397
- Chartier, M.J., Walker, J.R., Stein, M.B. (2003). Considering comorbidity in social phobia. *Social Psychiatry and Psychiatric Epidemiology* 38, 728–734. doi 10.1007/s00127-003-0720-6
- Chavira, D.A., Stein, M.B. (2005). Childhood Social Anxiety Disorder: From Understanding to Treatment. *Child Adolescent Psychology Cl*; 14(4), 797–818. doi:10.1016/j.chc.2005.05.003
- Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. (2004). Child anxiety in primary care: Prevalent but untreated. *Depression and Anxiety*, 20, 155–164. doi: 10.1002/da.20039
- Cheng, C. (2001). Accessing coping flexibility in real-life and laboratory settings: A multimethod approach. *Journal of Personality and Social Psychology*, 80, 814–833. doi:10.1037/0022-3514.80.5.814
- Cheung, Y. L., Molassiotis, A., Chang, A. M. (2003). The effect of progressive muscle relaxation training on anxiety and quality of life after stoma surgery in colorectal cancer patients. *Psycho-Oncology*, 12, 254-266.  
doi: 10.1002/pon.638
- Christon, L. M., Robinson, E. M., Arnold, C. C., Lund, H. G., Vrana, S. R., & Southam-Gerow, M. A. (2012). Modular Cognitive-Behavioral Treatment of an Adolescent Female With Selective Mutism and Social Phobia: A

Case Study. *Clinical Case Studies*, 11(6), 474–491.

doi: 10.1177/1534650112463956

Cisler, J., Olatunji, B., Feldner, M., & Forsyth, J. (2010). Emotion regulation and the anxiety disorders: An integrative review. *Journal of Psychopathology and Behavioral Assessment*, 32(1), 68–82. doi 10.1007/s10862-009-9161-1

Cisler, J. M., & Olatunji, B. O. (2012). Emotion Regulation and Anxiety Disorders. *Anxiety Curr Psychiatry Rep*. doi:10.1007/s11920-012-0262-2.

Clare, L. (2003). Managing threats to self: awareness in early stage Alzheimer's disease. *Social Science and Medicine* 57, 1017–1029. doi: 10.1016/S0277-9536(02)00476-8

Clark, D. M., Ehlers, A., McManus, F., Hackmann, A., Fennell, M., Campbell, H., et al. (2003). Cognitive therapy versus fluoxetine in generalized social phobia: A randomized placebo controlled trial. *Journal of Consulting and Clinical Psychology*, 71, 1058–1067. doi: 10.1037/0022-006X.71.6.1058

Clark, L., & Watson, D. (1991). Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, 100, 316–336. doi:10.1037/0021-843X.100.3.316

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In: R. Heimberg, M. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: diagnosis, assessment and treatment* (pp. 69–93). New York: Guilford Press.

- Clarke, P. N. & Yaros, P. S. (1988). Research blenders: Commentary and response. *Nursing Science Quarterly*, 1, 147–149.  
doi: 10.1177/089431848800100406
- Clerkin, E. M., & Teachman, B. A. (2010). Training implicit social anxiety associations: an experimental intervention. *Journal of Anxiety Disorders*, 24(3), 300–308. doi:10.1016/j.janxdis.2010.01.001
- Cobham, V. E., Dadds, M. R., & Spence, S. H. (1999). Anxious children and their families: What do they expect? *Journal of Clinical Child Psychology*, 28, 220-231. doi: 10.1207/s15374424jccp2802\_9
- Cole, P. M., Hall, S. E. (2008). Emotion dysregulation as a risk factor for psychopathology. In: *Beauchaine TP, Hinshaw SP (eds) Child and adolescent psychopathology*. Wiley, Hoboken, pp. 265–298.
- Cole, P. M., Michel, M. K., & Teti, L. O. (1994). The development of emotion regulation and dysregulation: a clinical perspective. *Monographs of the Society for Research in Child Development*, 59(2-3), 73–100.  
doi: 10.1111/j.1540-5834.1994.tb01278.x
- Cole, P. M., Zahn-Waxler, C., Fox, N. A., Usher, B. A., & Welsh, J. D. (1996). Individual differences in emotion regulation and behavior problems in preschool children. *Journal of Abnormal Psychology*, 105, 518–529. <http://dx.doi.org/10.1037/0021-843X.105.4.518>
- Collins, S., Woolfson, L. M., & Durkin, K. (2013). Effects on coping skills and anxiety of a universal school-based mental health intervention delivered in

- Scottish primary schools. *School Psychology International*, 35,(1), 85-100. doi:10.1177/0143034312469157
- Compton, S.N., March, J., Brent, D., Albano, A.M., Weersing, R., & Curry, J. (2004). Cognitive-behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: An evidence-based medicine review. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), 930–959. doi:10.1097/01.chi.0000127589.57468.bf
- Compton, S. N., Peris, T. S., Almirall, D., Birmaher, B., Sherrill, J., Kendall, P. C., et al. (2014). Predictors and moderators of treatment response in childhood anxiety disorders: results from the CAMS trial. *Journal of Consulting and Clinical Psychology*, <http://dx.doi.org/10.1037/a0035458>.
- Connell, A., & Goodman, S. (2002). The association between psychopathology in fathers versus mothers and children's internalizing and externalizing behavior problems: A meta-analysis. *Psychological Bulletin*, 128(5), 746-773. doi: 10.1037/0033-2909.128.5.746
- Conrad, A., & Roth, W. T. (2006). Muscle relaxation therapy for anxiety disorders: It works but how? *Journal of Anxiety Disorders*, 21, 243-264. doi: 10.1016/j.janxdis.2006.08.001
- Contreras, J. M., & Kerns, K. A. (2000). Emotion regulation processes: Explaining links between parent–child attachment and peer relationships. In K. A. Kerns, J. M. Contreras, & A. M. Neal-Barnett (Eds.), *Family and peers: Linking two social worlds* (pp. 1 – 25). Westport, CT: Praeger.

- Cooper, P. J., Gallop, C., Willetts, L. & Creswell, C. (2008). Treatment response in child anxiety is differentially related to the form of maternal anxiety disorder. *Behavioural and Cognitive Psychotherapy*, 36(1), 41–48. doi: 10.1017/S1352465807003943.
- Coplan, R. J., Arbeau, K. A., & Armer, M. (2008). Don't fret, be supportive! Maternal characteristics linking child shyness to psychosocial and school adjustment in kindergarten. *Journal of Abnormal Child Psychology*, 36, 359–371. doi 10.1007/s10802-007-9183-7
- Cowart, M. J. W. & Ollendick, T. H. (2010). Attention biases in children: implications for treatment. In: A. Hadwin, & A. Field (Eds.), *Information processing biases and anxiety: a developmental perspective* (pp. 297–319). Chichester: Wiley-Blackwell.
- Corcoran, K.M., & Woody, S.R. (2009). The importance of suppression and appraisals in the recurrence of intrusive thoughts; evidence in support of the cognitive theory of obsessions. *Behaviour Research and Therapy*, 47, 1024-1031.
- Costello, J. E., Egger, H. L., & Angold, A. (2004). Developmental epidemiology of anxiety disorders. In T. H. Ollendick, & March, J. S. (Eds.), *Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions* (pp. 61-91). New York: Oxford University Press.
- Costello, E. J., Egger, H. L., & Angold, A. (2005). The developmental epidemiology of anxiety disorders: Phenomenology, prevalence, and

comorbidity. *Child and Adolescent Psychiatric Clinics of North America*, 14, 631–648. doi:10.1016/j.chc.2005.06.003

Costello, E.J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003).

Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, 60, 837–844.

doi:10.1001/archpsyc.60.8.837.

Costello, E. J., Egger, H. L., Copeland, W., Erkanli, A., & Angold, A. (2011).

The developmental epidemiology of anxiety disorders: Phenomenology, prevalence, and comorbidity. In W. K. Silverman & A. P. Field (Eds.), *Anxiety disorders in children and adolescents* (2nd ed., pp. 56–75). New York: Cambridge University Press.

Cox, B. J., Fleet, C., & Stein, M. B. (2004). Self-criticism and social phobia in the US national comorbidity survey. *Journal of Affective Disorders*, 82, 227–234. doi: 10.1016/j.jad.2003.12.012

Crawley, S., Beidas, R. S., Benjamin, C., Martin, E., & Kendall, P. C. (2008).

Treating socially phobic youth with CBT: Differential outcomes and treatment considerations. *Behavioural and Cognitive Psychotherapy*, 36, 379–389. doi: 10.1017/S1352465808004542

Crawley, S. A., Kendall, P. C., Benjamin, C. L., Brodman, D. M., Wei, C.,

Beidas, R. S., Mauro, C. (2012). Brief Cognitive-Behavioral Therapy for Anxious Youth: Feasibility and Initial Outcomes. *Cognitive and Behavioral Practice*, 20,(2),123-133. doi: 10.1016/j.cbpra.2012.07.003



- Craske, M. G., Treanor, M., Conway, C. C., & Zbozinek, T. (2014). Maximizing exposure therapy: an inhibitory learning approach. *Behaviour Research and Therapy*, 58, 10–23. doi:10.1016/j.brat.2014.04.006
- Creed, A. T., & Funder, D. C. (1998). Social anxiety: From the inside and outside. *Personality and Individual Differences*, 25(1), 19–33.  
doi: 10.1016/S0191-8869(98)00037-3
- Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed approaches*. Thousand Oaks, CA: Sage.
- Creswell, J.W. & Miller, D.L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39 (3), 124-130. doi: 10.1207/s15430421tip3903\_2
- Creswell, C., & O'Connor, T. G. (2011). Interpretation bias and anxiety in childhood: Stability, specificity and longitudinal associations. *Behavioural and Cognitive Psychotherapy*, 39(2), 191–204. doi: 10.1017/S1352465810000494
- Crill Russell, C. (Ed.). (2003). *The state of knowledge about prevention/early intervention*. Toronto, ON: Invest in Kids Foundation.
- Crosby Budinger, M., Drazdowski, T. K., & Ginsburg, G. S. (2012). Anxiety-Promoting Parenting Behaviors: A Comparison of Anxious Parents with and without Social Anxiety Disorder. *Child Psychiatry & Human Development*, 44(3), 412-418. doi 10.1007/s10578-012-0335-9
- Crozier, M., Gillihan, S. J., & Powers, M. B. (2011). Issues in differential diagnosis: Phobias and phobic conditions. In D. McKay & E. A. Storch

(Eds.), *Handbook of child and adolescent anxiety disorders* (pp. 7–22).

New York: Springer.

Cummings, E. M., Davies, P. T. (2002). Effects of marital conflict on children:

Recent advances and emerging themes in process oriented research.

*Journal of Child Psychology and Psychiatry*, 43(1), 31-63.

doi: 10.1111/1469-7610.00003

Curtis, K., Liabo, K., Roberts, H. and Barker, M. (2004). Consulted but Not

Heard: A Qualitative Study of Young People's Views of Their Local

Health Service. *Health Expectations*, 7, (2), 149–156. doi: 10.1111/j.1369-

7625.2004.00265.x

Cutting, A. L., & Dunn, J. (1999). Theory of mind, emotion understanding,

language, and family background: individual differences and interrelations.

*Child Development*, 70, 853–865. doi: 10.1111/1467-8624.00061

Dadds, M. R., Holland, D. E., Laurens, K. R., Mullins, M., Barrett, P. M., & Spence,

S. H. (1999). Early intervention and prevention of anxiety disorders in

children: Results at 2-year follow-up. *Journal of Consulting and Clinical*

*Psychology*, 67, 145–150. doi:10.1037/0022-006X.67.1.145

Dahl, C. M., & Boss, P. (2005). The use of phenomenology for family therapy

research. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in*

*family therapy*. New York: The Guildford Press.

Dalrymple, K. L., Herbert, J. D., & Gaudiano, B. (2007). Onset of Illness and

Developmental Factors in Social Anxiety Disorder: Preliminary Findings

- from a Retrospective Interview. *Journal of Psychopathology and Behavioral Assessment*, 29(2), 101-110. doi: 10.1007/s10862-006-9033-x
- Dalrymple, K. L., & Zimmerman, M. (2011). Age of onset of social anxiety disorder in depressed outpatients. *Journal of Anxiety Disorders*, 25(1), 131-137. doi: 10.1016/j.janxdis.2010.08.012
- Dalton, K. M., Nacewicz, B. M., Johnstone, T., Schaefer, H. S., Gernsbacher, M. A., Goldsmith, H. H., et al. (2005). Gaze fixation and the neural circuitry of face processing in autism. *Nature Neuroscience*, 8, 519–526. doi: 10.1038/nn1421
- Daly, J. A., Vangelisti, A. L., & Lawrence, S. G. (1989). Self-focused attention and public speaking anxiety. *Personality and Individual Differences*, 10, 903–913. [http://dx.doi.org/10.1016/0191-8869\(89\)90025-1](http://dx.doi.org/10.1016/0191-8869(89)90025-1)
- Dane, A. V., & Schneider, B. H. (1998). Program integrity in primary and early secondary prevention: Are implementation effects out of control? *Clinical Psychology Review*, 18, 23–45. doi:10.1016/S0272-7358(97)00043-3
- Dannahy, L., & Stopa, L. (2007). Post-event processing in social anxiety. *Behaviour Research and Therapy*, 45, 1207-1219. doi:10.1016/j.brat.2006.08.017
- Datta, L. (1997). Multimethod evaluations: Using case studies together with other methods. In: E. Chelimsky & W. R. Shadish (eds.), *Evaluation for the 21st Century: A Handbook*. Thousand Oaks, CA: Sage Publications, pp. 344–359.

Darbyshire, P. (2005). Multiple methods in qualitative research with children: more insight or just more? *Qualitative Research*, 5(4), 417–436. doi: 10.1177/1468794105056921

Davidson, J.R., Hughes, D.L., George, L.K., & Blazer, D.G. (1993). The epidemiology of social phobia: Findings from the Duke Epidemiological Catchment Area Study. *Psychological Medicine*, 23(3), 709-718.  
<http://dx.doi.org/10.1017/S0033291700025484>

Davis III, T. E., Munson, M., & Tarzca, E. (2009). Anxiety disorders and phobias. In J. Matson (Ed.), *Social behavior and social skills in children* (pp. 219 – 244). New York: Springer Science and Business Media, LLC.

Davis, M., Robbins-Eshelman, E., & McKay, M. (2000). *The relaxation and stress reduction workbook*. New Harbinger. Oakland, CA.

Davis, M., & Whalen, P. J. (2001). The amygdala: Vigilance and emotion. *Molecular Psychiatry*, 6(1), 13–34.  
<http://dx.doi.org/10.1038/sj.mp.4000812>

Dearing, K. F., Hubbard, J. A., Ramsden, S. R., Parker, E. H., Relyea, N., Smithmyer, C. M., & Flanagan, K. D. (2002). Children’s self-reports about anger regulation: Direct and indirect links to social preference and aggression. *Merrill-Palmer Quarterly*, 48, 308-336. doi: 10.1353/mpq.2002.0011

Decker, M. L., Turk, C. L., Hess, B., & Murray, C. E. (2008). Emotion regulation among individuals classified with and without generalized

anxiety disorder. *Journal of Anxiety Disorders*, 22(3), 485–494.

doi:10.1016/j.janxdis.2007.04.002

Denham, S. A. (1998). *Emotional development in young children*. New York: Guilford Press.

Denham, S. A. (2006). Social-emotional competence as support for school readiness: what is it and how do we assess it? *Early Education and Development*, 17, 57–89. doi: 10.1207/s15566935eed1701\_4

Denham, S. A., Blair, K. A., DeMulder, E., Levitas, J., Sawyer, K., Auerbach-Major, S., & Queenan, P. (2003). Preschool emotional competence: Pathway to social competence. *Child Development*, 74, 238-256. doi: 10.1111/1467-8624.00533

Denham S. A., Caverly S., Schmidt M., Blair K., DeMulder E., Caal S. (2002a). Preschool understanding of emotions: Contributions to classroom anger and aggression. *Journal of Child Psychology and Psychiatry*; 43, 901–916. doi: 10.1111/1469-7610.00139

Denham, S. A., & Grout, L. (1993). Socialization of emotion: Pathways to preschoolers' emotional and social competence. *Journal of Nonverbal Behaviour*, 17, 205–227. doi: 10.1007/BF00986120

Denham, S. A., Mason, T., & Couchoud, E. A. (1995). Scaffolding young children's prosocial responsiveness: preschoolers' responses to adult sadness, anger, and pain. *International Journal of Behavior Development*, 18, 489–504. doi: 10.1177/016502549501800306

- Denham, S., von Salisch, M., Olthof, T., Kochanoff, A., & Caverly, S. (2002b). Emotional and Social Development in Childhood. In P.K. Smith & C.H. Hart (Eds.). *Childhood Social Development*. Malden, MA: Blackwell Publishing.
- Denzin, M. K. (1995). Symbolic interaction. In J. A. Smith, R. Harre, & L. V. Langenhove (Eds.), *Rethinking psychology*. London: Sage Publications.
- Denzin, N. K. & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In: N. K. Denzin & Y. S. Lincoln (eds.), *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage, pp. 1–17.
- Depape, A. M. R., Hakim-Larson, J., Voelker, S., Page, S., & Jackson, D. L. (2006). Self- talk and emotional intelligence in university students. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, 38, 250-260. doi: 10.1037/cjbs2006012
- Department of Health. (1999). *A national service framework for mental health*. London: Department of Health.
- Department of Health. (2006). *Our health, our care, our say: a new direction for community services*. London: Department of Health.
- Department of Health. (2007). *Commissioning framework for health and wellbeing*. London: Department of Health.
- DeRubeis, R. J., Evans, M. D., Hollon, S. D., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1990). How does cognitive therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for

- depression. *Journal of Consulting and Clinical Psychology*, 58, 862-869.  
doi:10.1037/0022-006X.58.6.862
- Devine, D. (2002). Children's Citizenship and the Structuring of Adult-Child Relations in the Primary School. *Childhood*, 9, (3), 303-320.  
doi: 10.1177/0907568202009003044
- De Waal, C. (2001). *On Peirce*. Belmont, CA: Wadsworth.
- Deyo, M., Wilson, K. A., Ong, J., & Koopman, C. (2009). Mindfulness and rumination: Does mindfulness training lead to reductions in the ruminative thinking associated with depression? *Explore*, 5, 265-271.  
doi:10.1016/j.explore.2009.06.005
- Dineen, K. A., & Hadwin, J. A. (2004). Anxious and depressive symptoms and children's judgements of their own and others' interpretation of ambiguous social scenarios. *Journal of Anxiety Disorders*, 18(4), 499-513.  
doi:10.1016/S0887-6185(03)00030-6
- Dix, T. (1991). The affective organization of parenting: adaptive and maladaptive processes. *Psychology Bulletin*, 110, 3-25.  
<http://dx.doi.org/10.1037/0033-2909.110.1.3>
- Dockett, S., & Perry, B. (2003). 'Children's Views and Children's Voices in Starting School'. *Australian Journal of Early Childhood*, 28, (1), 12-17.
- Dolbier, C. L., & Rush, T. E. (2012). Efficacy of abbreviated progressive muscle relaxation in a high-stress college sample. *International Journal of Stress Management*, 19, 48-68. doi: 10.1037/a0027326

- Donovan, C. L., & Spence, S. H. (2000). Prevention of childhood anxiety disorders. *Clinical Psychology Review*, 20, 509–531. doi:10.1016/S0272-7358(99)00040-9
- Drummond, P.D., Back, K., Harrison, J., Helgadottir, F.D., Lange, B., Lee, C., Leavy, K., Novatscou, C., Orner, A., Pham, H., Prance, J., Radford, D., Wheatley, L., (2007). Blushing during social interactions in people with a fear of blushing. *Behaviour Research and Therapy* 45, 1601–1608. doi: 10.1016/j.brat.2006.06.012
- Dunn, J., & Brown, J. (1994). Affect expression in the family, children's understanding of emotions, and their interactions with others. *Merrill-Palmer Quarterly*, 40, 120–137.
- Dzurec, L. C., & Abraham, J. L. (1993). The nature of inquiry: Linking quantitative and qualitative research. *Advances in Nursing Science*, 16, 73–79. doi: 10.1097/00012272-199309000-00009
- Eatough, V., & Smith, J. (2006). “I was like a wild wild person”: understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology (London, England : 1953)*, 97(Pt 4), 483–98. doi: 10.1348/000712606X97831
- Eatough, V. & Smith, J. A. (2008). Interpretative Phenomenological Analysis. In *Qualitative research in psychology*, (ed. C. Wilig and W. Stainton-Rogers), pp. 179-194. Sage: London.



- Edelmann, R.J., Baker, S.R. (2002). Self-reported and actual physiological responses in social phobia. *British Journal of Clinical Psychology* 41, 1–14. doi: 10.1348/01446650216373
- Edwards, S. L., Rapee, R. M., & Franklin, J. (2003). Post-event rumination and recall bias for social performance event in high and low socially anxious individuals. *Cognitive Therapy and Research*, 27(6), 603-617.  
10.1023/A:1026395526858
- Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47, 313–337. doi: 10.1111/j.1469-7610.2006.01618.x
- Egloff, B., Schmukle, S. C., Burns, L. R., & Schwerdtfeger, A. (2006). Spontaneous emotion regulation during evaluated speaking tasks: Associations with negative affect, anxiety expression, memory, and physiological responding. *Emotion*, 6, 356–366. doi:10.1037/1528-3542.6.3.356
- Ehrenreich-May, J., & Chu, B. C. (Eds.). (2014). *Transdiagnostic mechanisms and treatment for youth psychopathology*. New York, NY: Guilford Press.
- Eisenberg, N., Cumberland, A., & Spinrad, T. (1998). Parental socialization of emotion. *Psychological Inquiry*, 9(4), 241–273. doi: 10.1207/s15327965pli0904\_1
- Eisenberg, N., Cumberland, A., & Spinrad, T. Fabes, R. A., Shepard, S. A., Reiser, M. et al (2001a) The relations of regulation and emotionality to

children's externalizing and internalizing problem behavior. *Child Development* 72, 1112–1134. doi: 10.1111/1467-8624.00337

Eisenberg, N., & Fabes, R. A. (1992a). Emotion, regulation, and the development of social competence. In M. S. Clark (Ed.), *Review of personality and social psychology: Emotion and social behaviour* (pp. 119–150). Newbury Park, CA: Sage.

Eisenberg, N., & Fabes, R. A. (1994). Mother's reactions to children's negative emotions: Relations to children's temperament and anger behavior. *Merrill-Palmer Quarterly*, 40, 138-156.

Eisenberg, N., Fabes, R. A., Bernzweig, J., Karbon, M., Poulin, R., & Hanish, L. (1993). The relations of emotionality and regulation to preschoolers' social skills and sociometric status. *Child Development*, 64, 1418-1438. doi: 10.1111/j.1467-8624.1993.tb02961.x

Eisenberg, N, Fabes, R.A., Carlo, G., Troyer, D., & Karbon, M. (1992b). The relations of maternal practices and characteristics to children's vicarious emotional responsiveness. *Child Development*, 63, 583-602. doi: 10.1111/j.1467-8624.1992.tb01648.x

Eisenberg, N., Fabes, R. A., Guthrie, I. K., Murphy, B. C., Maszk, P., Holmgren, R., & Suh, K. (1996a). The relations of regulation and emotionality to problem behavior in elementary school children. *Development and Psychopathology*, 8, 141-162. doi: 10.1017/S095457940000701X

Eisenberg, N., Fabes, R. a., Guthrie, I. K., Murphy, B. C., Maszk, P., Holmgren, R., & Suh, K. (2009). The relations of regulation and emotionality to

problem behavior in elementary school children. *Development and Psychopathology*, 8(01), 141-162.

<http://dx.doi.org/10.1017/S095457940000701X>

Eisenberg, N., Fabes, R. A., Guthrie, I. K., & Reiser, M. (2000a). Dispositional emotionality and regulation: Their role in predicting quality of social functioning. *Journal of Personality and Social Psychology*, 78, 136-157.  
doi: 10.1037//0022-3514.78.1.136

Eisenberg, N., Fabes, R. A., Murphy, B. C., Maszk, P., Smith, M., & Karbon, M. (1995b). The role of emotionality and regulation in children's social functioning: A longitudinal study. *Child Development*, 66, 1360-1384.  
doi: 10.1111/j.1467-8624.1995.tb00940.x

Eisenberg, N., Fabes, R. A., & Murphy, B. C. (1996b). Parents' reactions to children's negative emotions: Relations to children's social competence and comforting behavior. *Child Development*, 67, 2227-2247.  
doi: 10.1111/j.1467-8624.1996.tb01854.x

Eisenberg, N., Fabes, R. A., & Losoya, S. (1997). Emotional responding: Regulation, social correlates, and socialization. In P. Salovey & D. J. Sluyter (Eds.), *Emotional development and emotional intelligence: Educational implications* (pp. 129-163). New York: Basic Books.

Eisenberg, N., Gershoff, E. T., Fabes, R. A., Shepard, S. A., Cumberland, A. J., Losoya, S. H., et al. (2001b). Mothers' emotional expressivity and children's behaviour problems and social competence: Mediation through

children's regulation. *Developmental Psychology*, 37, 475– 490. doi:  
10.1037//0012-1649.37.4.475

Eisenberg, N., Guthrie, I. K., Fabes, R. A., Shepard, S. A., Losoya, S., Murphy, B. C., Jones, S. Poulin, R., & Reiser, M. (2000b). Prediction of elementary school children's externalising problem behaviours from attentional and behavioural regulation and negative emotionality. *Child Development*, 71, 1367-1382. doi: 10.1111/1467-8624.00233

Eisenberg, N., Hofer, C., & Vaughan, J. (2007). Effortful control and its socioemotional consequences. In J. J. Gross (ed.), *Handbook of emotion regulation* (pp. 287-306). New York: Guilford Press.

Eisenberg, N., Losoya, S., Fabes, R., Guthrie, I., Reiser, M., Murphy, B., Shepard, S., Poulin, R., & Padgett, S. (2001c). Parental socialization of children's dysregulated expression of emotion and externalizing problems. *Journal of Family Psychology*, 15, 183-205. doi:10.1037//0893-3200.15.2.183

Elias, M. J., Zins, J. E., Weissberg, R. P., Frey, K. S., Greenberg, M. T., Haynes, N. M., et al. (1997). *Promoting social and emotional learning: Guidelines for educators*. Alexandria, VA: Association for Supervision and Curriculum Development.

Elliott, R. (2008). Research on client experiences of therapy: introduction to the special section. *Psychotherapy Research*, 18, 239–242. doi:  
10.1080/10503300802074513

- Emery, N. J. (2000). The eyes have it: The neuroethology, function and evolution of social gaze. *Neuroscience and Biobehavioral Reviews*, 24, 581–604.  
doi: 10.1016/S0149-7634(00)00025-7
- Erwin, B. A., Heimberg, R. G., Juster, H., & Mindlin, M. (2002). Comorbid anxiety and mood disorders among persons with social anxiety disorder. *Behaviour Research and Therapy*, 40(1), 19–35. doi:10.1016/S0005-7967(00)00114-5
- Erwin, B. A., Heimberg, R. G., Schneier, F. R., & Liebowitz, M. R. (2003). Anger experience and expression in social anxiety disorder: Pretreatment profile and predictors of attrition and response to cognitive-behavioral treatment. *Behavior Therapy*, 34(3), 331–350. doi:10.1016/S0005-7894(03)80004-7
- Essau, C. A. (2005). Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. *Depression and Anxiety*, 22(3), 130–137. doi: 10.1002/da.20115
- Essau, C. A. (2007). Editorial: Anxiety in children: When is it classed as a disorder that should be treated? *Expert Review of Neurotherapeutics*, 7, 909–911. doi: 10.1586/14737175.7.8.909
- Essau, C. A., Anastassiou-hadjicharalambous, X., Demetriou, C. & Pourseied, K. (2013). *Cultural Factors and Anxiety in Children and Adolescents*. In: Essau, C.A., & Ollendick, T. *The Wiley-Blackwell Handbook of the Treatment of Childhood and Adolescent Anxiety* (1<sup>st</sup> Edition). London, UK: John Wiley & Sons, Ltd.

- Essau, C. A., Conradt, J., & Petermann, F. (1999). Frequency and comorbidity of social phobia and social fears in adolescents. *Behaviour Research and Therapy*, 37, 831–843. doi:10.1016/S0005-7967(98)00179-X
- Essau, C.A., Conradt, J., & Petermann, F. (2000). Frequency, comorbidity, and psychosocial impairment of depressive disorders in adolescents. *Journal of Adolescent Research*, 15(4), 470-481. doi: 10.1177/0743558400154003
- Essau, C. A., Conradt, J., Sasagawa, S., & Ollendick, T. H. (2012). Prevention of Anxiety Symptoms in Children : Results from a Universal School-Based Trial. *Behaviour Therapy*, 43(2), 450–464. doi: 10.1016/j.beth.2011.08.003
- Essau, C. A., Muris, P., & Ederer, E. M. (2002). Reliability and validity of the “Spence Children’s Anxiety Scale” and the “Screen for Child Anxiety Related Emotional Disorders” in German children. *Journal of Behavior Therapy and Experimental Psychiatry*, 33, 1–18. doi: 10.1016/S0005-7916(02)00005-8
- Essau, C. a, Olaya, B., Sasagawa, S., Pithia, J., Bray, D., & Ollendick, T. H. (2014). Integrating video-feedback and cognitive preparation, social skills training and behavioural activation in a cognitive behavioural therapy in the treatment of childhood anxiety. *Journal of Affective Disorders*, 167C, 261–267. <http://dx.doi.org/10.1016/j.jad.2014.05.056>
- Essau, C.A., & Ollendick, T. (2013). *The Wiley-Blackwell Handbook of the Treatment of Childhood and Adolescent Anxiety* (1<sup>st</sup> Edition). London, UK: John Wiley & Sons, Ltd.

- Essau, C.A., Petermann, F. (Eds.) (2001). *Anxiety disorders in children and adolescents: Epidemiology, risk factors, and treatment*. London: Brunner-Routledge.
- Evren, B., & Evren, C. (2007). Relationship between alexithymia and social anxiety in female outpatients with dermatological disorder presenting for psychiatric consultation. *Journal of Clinical Psychology in Medical Settings*, 14, 258-265. doi 10.1007/s10880-007-9072-9
- Eysenck, M. W. (2004). *Anxiety, stress, and coping: the past 25 years*. Paper presented at the 25th Stress and anxiety research society conference, Amsterdam, The Netherlands. Book of abstracts.
- Fabes, R. A., Leonard, S. A., Kupanoff, K., & Martin, C. L. (2001). Parental coping with children's negative emotions: Relations with children's emotional and social responding. *Child Development*, 72, 907-920. doi: 10.1111/1467-8624.00323
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society*, 63, 647–653. doi:10.1079/PNS2004398
- Farmer, A. S., & Kashdan, T. B. (2012). Social Anxiety and Emotion Regulation in Daily Life: Spillover Effects on Positive and Negative Social Events. *Cognitive behaviour therapy*, 41, (1), 152-162. doi: 10.1080/16506073.2012.666561
- Farrell, L. J., & Barrett, P. M. (2007). Prevention of childhood emotional disorders: Reducing the burden of suffering associated with anxiety and

depression. *Child and Adolescent Mental Health*, 12, 58–65.

doi: 10.1111/j.1475-3588.2006.00430.x

Fedoroff, I. C., & Taylor, S. T. (2001). Psychological and pharmacological treatments of social phobia: A meta-analysis. *Journal of Clinical Psychopharmacology*, 21, 311–324. doi: 10.1097/00004714-200106000-00011

Fehm, L., Beesdo, K., Jacobi, F., & Fiedler, A. (2008). Social anxiety disorder above and below the diagnostic threshold: prevalence, comorbidity and impairment in the general population. *Social Psychiatry and Psychiatric Epidemiology*, 43(4), 257–265. doi 10.1007/s00127-007-0299-4

Felner, R. D., Brand, S., Adan, A. M., Mulhall, P. F., Flowers, N., Sartain, B., & DuBois, D. L. (1993). Restructuring the ecology of the school as an approach to prevention during school transitions: Longitudinal follow-ups and extensions of the School Transitional Environment Project (STEP). *Prevention in Human Services*, 10, 103–136. doi:10.1300/J293v10n02\_07

Feng, X., Shaw, D., Kovacs, M., Lane, T., O'Rourke, F., & Alarcon, J. (2008). Emotion regulation in preschoolers: The roles of behavioral inhibition, maternal affective behavior, and maternal depression. *Journal of Child Psychology and Psychiatry*, 49, 132–141. doi: 10.1111/j.1469-7610.2007.01828.x

Fergus, T. A., Valentiner, D. P., Kim, H.-S., & Stephenson, K. (2009). The social thoughts and beliefs scale: Psychometric properties and its relation with



- interpersonal functioning in a non-clinical sample. *Cognitive Therapy and Research*, 33, 425–431. doi 10.1007/s10608-008-9214-x
- Fernyhough, C., & Fradley, E. (2005). Private speech on an executive task: Relations with task difficulty and task performance. *Cognitive Development*, 20, 103–120. doi:10.1016/j.cogdev.2004.11.002
- Festa, C. C., & Ginsburg, G. S. (2011). Parental and peer predictors of social anxiety in youth. *Child Psychiatry and Human Development*, 42, 291–306. doi 10.1007/s10578-011-0215-8
- Field, T. (1994). The effects of mother's physical and emotional unavailability on emotion regulation. *Monographs of the Society for Research in Child Development*, 59, 208–227. doi: 10.1111/j.1540-5834.1994.tb01286.x
- Field, A. P. (2005). *Discovering Statistics Using SPSS (Second Edition)*. London: Sage.
- Fine S. E., Izard C. E., Mostow A. J., Trentacosta C. J., Ackerman B. P. (2003). First grade emotion knowledge as a predictor of fifth grade self-reported internalizing behaviours in children from economically- disadvantaged families. *Development and Psychopathology*; 15, 331–345. <http://dx.doi.org/10.1017/S095457940300018X>
- Fisak, B., & Grills-Tauechel, A. E. (2007). Parental modeling, reinforcement, and information transfer: risk factors in the development of child anxiety? *Clinical child and family psychology review*, 10(3), 213–31. doi: 10.1007/s10567-007-0020-x

- Fisak, B., Richard, D., & Mann, A. (2011). The prevention of child and adolescent anxiety: A meta-analytic review. *Prevention Science*, 12(3), 255-268. doi: 10.1007/s11121-011-0210-0.
- Fischer, C. T. & Wertz, F. J. (1979). Empirical phenomenological analyses of being criminally victimized. In A. Giorgi, R. Knowles & D. L. Smith (Eds), *Duquesne studies in phenomenological psychology* (Vol. 3), pp. 135±158. Pittsburgh: Duquesne University Press.
- Fisher, P. H., Masia-Warner, C., & Klein, R. G. (2004). Skills for social and academic success: a school-based intervention for social anxiety disorder in adolescents. *Clinical Child and Family Psychology Review*, 7(4), 241–249. doi: 10.1007/s10567-004-6088-7
- Fiske, S. & Taylor, S. (1991). *Social cognition, second edition*. New York: Mcgraw Hill.
- Fivush R., Brotman, M. A., Buckner, J. P., & Goodman, S. H. (2000). Gender differences in parent-child emotion narratives. *Sex Roles*, 42(3-4), 233-253. doi: 10.1023/A:1007091207068
- Flannery-Schroeder, E. C., & Kendall, P. C. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: A randomized clinical trial. *Cognitive Therapy and Research*, 24(3), 251–278. doi: 10.1023/A:1005500219286
- Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., et al. (2005). Standards of evidence: Criteria for efficacy, effectiveness and

dissemination. *Prevention Science*, 6, 151–175. doi: 10.1007/s11121-005-5553-y

Flouri, E., & Mavroveli, S. (2012). Adverse Life Events and Emotional and Behavioural Problems in Adolescence: The Role of Coping and Emotion Regulation. *Stress and health: Journal of the International Society for the Investigation of Stress*, 1966. doi:10.1002/smi.2478

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20–35.  
<http://dx.doi.org/10.1037/0033-2909.99.1.20>

Forgas, J.P. (1995). Mood and judgment: The Affect Infusion Model (AIM). *Psychological Bulletin*, 11, 39–66. <http://dx.doi.org/10.1037/0033-2909.117.1.39>

Foss, C., Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Journal of Advanced Nursing*, 40, (2), 242–248. doi: 10.1046/j.1365-2648.2002.02366.x

Fox, N. A. (Eds.). (1994). The development of emotion regulation: biological and behavioral considerations. *Monographs of the Society for Research in Child Development*, 59 (2–3) (Serial No. 240).

Fox, N.A., & Calkins, S.D. (2003). The development of self-control of emotion: Intrinsic and extrinsic influences. *Motivation and Emotion*, 27, 7–26. doi: 10.1023/A:1023622324898

- Fredrickson, B. L. (1998). What good are positive emotions? *Review of General Psychology*, 2, 300–319. <http://dx.doi.org/10.1037/1089-2680.2.3.300>
- Fresco, D. M., Mennin, D. S., Heimberg, R. G., & Ritter, M. (2013). Emotion Regulation Therapy for Generalized Anxiety Disorder. *Cognitive and Behavioral Practice*, 20(3), 282–300. doi: 10.1016/j.cbpra.2013.02.00
- Frick, P., Morris, A. S. (2004). Temperament and developmental pathways to conduct problems. *Journal of Clinical Child and Adolescent Psychology*, 33, 54–68. doi: 10.1207/S15374424JCCP3301\_6
- Friedlmeier, W., & Trommsdorff, G. (1999). Emotion regulation in early childhood: a cross-cultural comparison between German and Japanese toddlers. *Journal of Cross-Cultural Psychology*, 30, 684–711. doi: 10.1177/0022022199030006002
- Friedman, M. L., & Friedlander, M. L. (2005). Toward an understanding of Jewish identity: A phenomenological study. *Journal of Counselling Psychology*, 52(1), 77–83. doi: 10.1037/0022-0167.52.1.77
- Frijda, N. H. (1986). *The emotions*. London, England: Cambridge University Press.
- Frijda, N. H. (1988). The laws of emotion. *American Psychologist*, 43, 349-358. doi:10.1037/0003-066X.43.5.349
- Fyer, A. J. (1993). Heritability of social anxiety: A brief review. *Journal of Clinical Psychiatry*, 54, 10–12.

- Fuchs D., & Thelen, M. (1988). Children's expected interpersonal consequences of communicating their affective state and reported likelihood of expression. *Child Development*, 59, 1314–1322.  
<http://dx.doi.org/10.2307/1130494>
- Furmark, T. (2002). Social Phobia: Overview of community surveys. *Acta Psychiatrica Scandinavica*, 105, 84-93. doi: 10.1034/j.1600-0447.2002.1r103.x
- Fydrich, T., Chambless, D. L., Perry, K. J., Buergener, F., & Beazley, M. B. (1998). Behavioral assessment of social performance: a rating system for social phobia. *Behaviour Research and Therapy*, 36, 995–1010.  
doi:10.1016/S0005-7967(03)00158-X
- Gallagher, H. M., Rabian, B. a, & McCloskey, M. S. (2004). A brief group cognitive-behavioral intervention for social phobia in childhood. *Journal of anxiety disorders*, 18(4), 459–479. doi:10.1016/S0887-6185(03)00027-6
- Garber, J., Braafladt, N., Zeman, J. (1991). The regulation of sad affect: an information-processing perspective. In: Garber J, Dodge KA (eds) *The development of emotion regulation and dysregulation*. Cambridge University Press, New York, pp. 208–240.
- Gardner, H. (1999). *Intelligence reframed: Multiple intelligences for the 21st century*. New York: Basic Books.
- Garland, E., Gaylord, S., & Park, J. (2009). The Role of Mindfulness in Positive Reappraisal. *Explore*, 5, 37-44. doi:10.1016/j.explore.2008.10.001

- Garnefski, N., Kraaij, V., & Spinhoven, P (2001). Negative life events, cognitive emotion regulation and depression. *Personality and Individual Differences*, 30, 1311-1327. doi:10.1016/S0191-8869(00)00113-6
- Garner, P. W., & Power, T. G. (1996). Preschoolers' emotional control in the disappointment paradigm and its relation to temperament, emotional knowledge, and family expressiveness. *Child Development*, 67, 1406–14. doi: 10.2307/1131708
- Gauer, G. J., Picon, P., Vasconcellos, S. J., Turner, S. M., & Beidel, D. C. (2005). Validation of the social phobia and anxiety inventory for children (SPAI-C) in a sample of Brazilian children. *Brazilian Journal of Medical and Biological Research* 38(5), 795-800. <http://dx.doi.org/10.1590/S0100-879X2005000500019>
- Gazelle, H., & Ladd, G. W. (2003). Anxious solitude and peer exclusion: A diathesis–stress model of internalizing trajectories in childhood. *Child Development*, 74(1), 257–278. doi: 10.1111/1467-8624.00534
- Gerull, F. C., & Rapee, R. M. (2002). Mother knows best: The effects of maternal modelling on the acquisition of fear and avoidance behaviour in toddlers. *Behaviour Research and Therapy*, 40(3), 279–287. doi:10.1016/S0005-7967(01)00013-4
- George, L., & Stopa, L. (2008). Private and public self-awareness in social anxiety. *Journal of Behavior Therapy and Experimental Psychiatry*, 39, 57-72. doi:10.1016/j.jbtep.2006.09.004

- Gillham, J. E., Reivich, K. J., Freres, D. R., Lascher, M., Litzinger, S., & Shatte, A. (2006). School-based prevention of depression and anxiety symptoms in early adolescence: a pilot of a parent intervention component. *School Psychology Quarterly*, 21, 323–348. doi: 10.1521/scpq.2006.21.3.323
- Gillham, J. E., Shatté, A. J., & Reivich, K. (2001). Needed for prevention research: Long-term follow-up and the evaluation of mediators, moderators, and lay providers. *Prevention & Treatment*, 1(4), 9c. doi:10.1037/1522-3736.4.1.49c
- Ginsberg, G. S., La Greca, A. M. & Silverman, W. K. (1998). Social Anxiety in children with anxiety disorders: Relation with social and emotional functioning. *Journal of Abnormal Child Psychology* 26: 175-185. doi: 10.1023/A:1022668101048
- Ginsburg, G. S., Becker, K. D., Drazdowski, T. K., & Tein, J.-Y. (2011). Treating Anxiety Disorders in Inner City Schools: Results from a Pilot Randomized Controlled Trial Comparing CBT and Usual Care. *Child & Youth Care Forum*, 1(41), 1-19. doi 10.1007/s10566-011-9156-4
- Ginsburg, G. S., Siqueland, L., Masia-Warner, C., & Hedtke, K. A. (2004). Anxiety disorders in children: family matters. *Cognitive & Behavioral Practice*, 11, 28–43. doi:10.1016/S1077-7229(04)80005-1
- Giorgi, A. (1995). Phenomenological psychology. In J. A. Smith, R. Harre, & L. V. Langenhove (Eds.), *Rethinking psychology*. London: Sage Publications.

- Glasgow, R. E., & Arkowitz, H. (1975). The behavioral assessment of male and female social competence in dyadic heterosexual interactions. *Behavior Therapy*, 6, 488-498. [http://dx.doi.org/10.1016/S0005-7894\(75\)80005-0](http://dx.doi.org/10.1016/S0005-7894(75)80005-0)
- Goldin, P. R., Manber, T., Hakimi, S., Canli, T., & Gross, J. J. (2009a). Neural bases of social anxiety disorder: Emotional reactivity and cognitive regulation during social and physical threat. *Archives of General Psychiatry*, 66(2), 170–180. doi: 10.1001/archgenpsychiatry.2008.525
- Goldin, P. R., Manber-Ball, T., Werner, K., Heimberg, R., & Gross, J. J. (2009b). Neural mechanisms of cognitive reappraisal of negative self-beliefs in social anxiety disorder. *Biological Psychiatry*, 66(12), 1091–1099. doi:10.1016/j.biopsych.2009.07.014
- Goldman J. A ., Corsini D. A., DeUrioste R. (1980). Implications of positive and negative sociometric status for assessing the social competence of young children. *Journal of Applied Developmental Psychology*, 1(3), 209–220. doi:10.1016/0193-3973(80)90010-6
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 38(5), 581–586. doi: 10.1111/j.1469-7610.1997.tb01545.x
- Goodman, R., Meltzer, H., & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, 7(3), 125–130. doi: 10.1007/s007870050057
- Goodman, R., & Scott, S. (1997). *Child Psychiatry*. Oxford: Blackwell Science.



- Goodwin, R. D., Fergusson, D. M., & Horwood, J. (2004). Early anxious/withdrawn behaviors predict later internalizing disorders. *Journal of Child Psychology and Psychiatry*, 45, 874–883. doi: 10.1111/j.1469-7610.2004.00279.x
- Gottfredson, G. D., Gottfredson, D. C., Czech, E. R., Cantor, D., Crosse, S. B., & Hantman, I. (2000). *National study of delinquency prevention in schools*. Ellicott City, MD: Gottfredson Associates.
- Gottman, J. M., Katz, L. F., & Hooven, C. (1996). Parental meta-emotion philosophy and the emotional life of families: Theoretical models and preliminary data. *Journal of Family Psychology*, 10, 243–268. doi:10.1037/0893-3200.10.3.243
- Gottman J. M., Gonso J., Rasmussen B. (1975). Social interaction, social competence, and friendship in children. *Child Development*, 46, 709–718. <http://dx.doi.org/10.2307/1128569>
- Gottman, J.M., Guralnick, M. J., Wilson, B., Swanson, C. C., & Murray, J. D. (1997). What should be the focus of emotion regulation in children? A nonlinear dynamic mathematical model of children's peer interaction in groups. *Development and Psychopathology*, 9(2), 421–452. <http://dx.doi.org/10.1017/S0954579497002113>
- Greene, J. C., & Caracelli, V. J. (eds) (1997). *Advances in Mixed-Method Evaluation: The Challenges and Benefits of Integrating Diverse Paradigms*. San Francisco: Jossey-Bass Publishers.

- Gregory, A. M., & Eley, T. C. (2011). The genetic basis of child and adolescent anxiety. In W. K. Silverman & A. P. Field (Eds.), *Anxiety disorders in children and adolescents* (2nd ed., pp. 161–178). New York: Cambridge University Press.
- Gullone, E., Hughes, E. K., King, N. J., & Tonge, B. (2010). The normative development of emotion regulation strategy use in children and adolescents: A 2-year follow-up study. *Journal of Child Psychology and Psychiatry*, 51(5), 567–574. doi: 10.1111/j.1469-7610.2009.02183.x
- Gullone, E., King, N. J., & Ollendick, T. H. (2001). Self-reported anxiety in children and adolescents: a three-year follow-up study. *The Journal of Genetic Psychology*, 162(1), 5–19. doi: 10.1080/00221320109597878
- Gullone, E., & Lane, B. (2002). The fear survey schedule for children. II: A validity examination across response format and instruction type. *Clinical Psychology & Psychotherapy*, 9(1), 55–67. doi: 10.1002/cpp.327
- Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In: N. K. Denzin & Y. S. Lincoln (eds), *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage, pp. 105–117.
- Guerrero, L. K., Jones, S. M., & Burgoon, J. K. (2000). Responses to nonverbal intimacy change in romantic dyads: Effects of behavioral valence and degree of behavioral change on nonverbal and verbal reactions. *Communication Monographs*, 67(4), 325–346.  
doi: 10.1080/03637750009376515

- Graziano, P. A., Reavis, R. D., Keane, S. P., & Calkins, S. D. (2007). The role of emotion regulation in children's early academic success. *Journal of School Psychology, 45*(1), 3–19. doi: 10.1016/j.jsp.2006.09.002
- Gross, J. J. (1998a). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2* (3), 271-299. doi:10.1037/1089-2680.2.3.271
- Gross, J. J. (1998b). Antecedent- and response-focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Social Psychology, 74*(1), 224–237. doi:10.1037/0022-3514.74.1.224
- Gross, J. J. (2001). Emotion regulation in adulthood: Timing is everything. *Current Directions in Psychological Science, 10*(6), 214–219. doi: 10.1111/1467-8721.00152
- Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281–291. doi: 10.1017.S0048577201393198
- Gross, J. J. (Ed). (2007). *Handbook of emotion regulation*. New York: Guilford Press.
- Gross, J. J. (2013). Emotion regulation: Taking stock and moving forward. *Emotion*. Advance online publication.
- Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being.

*Journal of Personality and Social Psychology*, 85(2), 348–362.

doi:10.1037/0022-3514.85.2.348

Gross, J. J., & Levenson, R. W. (1997). Hiding feelings: The acute effects of inhibiting negative and positive emotion. *Journal of Abnormal Psychology*, 106(1), 95–103. doi:10.1037/0021-843X.106.1.95

Gross, J. J., & Levenson, R. W. (1993). Emotional suppression: Physiology, self-report, and expressive behavior. *Journal of Personality and Social Psychology*, 64(6), 970–986. doi:10.1037/0022-3514.64.6.970

Gross, J. J., & Muñoz, R. F. (1995). Emotion regulation and mental health.

*Clinical Psychology: Science and Practice*, 2(2), 151–164.

doi: 10.1111/j.1468-2850.1995.tb00036.x

Gross, J. J., Richards, J. M., & John, O. P. (2006). Emotion regulation in everyday life. In D. K. Snyder, J. A. Simpson, & J. N. Hughes (Eds.), *Emotion regulation in couples and families: Pathways to dysfunction and health* (pp. 13–35). Washington, DC: American Psychological Association.

Gross, J.J., Thompson, R.A., (2009). Emotion regulation: conceptual foundations. In: Gross, J.J. (Ed.), *Handbook of emotion regulation*. The Guilford Press, New York, pp. 3–24.

Gruber, J., Harvey, A. G., & Gross, J. J. (2012). When trying is not enough: emotion regulation and the effort-success gap in bipolar disorder. *Emotion*, 12(5), 997–1003. doi:10.1037/a0026822

- Hackfort, D., & Schwenkmezger, P. (1993). Anxiety. In R. N. Singer, M. Murphey, & L. K. Tennant, (Eds.), *Handbook of research on sport psychology* (pp. 328-549). New York, NY: Macmillan.
- Hadwin, J. A., Donnelly, N., French, C. C., Richards, A., Watts, A., & Daley, D. (2003). The influence of children's self-report trait anxiety and depression on visual search for emotional faces. *Journal of Child Psychology and Psychiatry*, 44(3), 432–444. doi: 10.1111/1469-7610.00133
- Hadwin, J. A., Garner, M., & Perez-Olivas, G. (2006). The development of information processing biases in childhood anxiety: A review and exploration of its origins in parenting. *Clinical Psychology Review*, 26(7), 876–894. doi:10.1016/j.cpr.2005.09.004
- Haga, S. M., Kraft, P., & Corby, E. (2009). Emotion regulation: Antecedents and well-being outcomes of cognitive reappraisal and expressive suppression in cross-cultural samples. *Journal of Happiness Studies*, 10 (3), 271-291. doi 10.1007/s10902-007-9080-3
- Hains, A. A. (1992). Comparison of cognitive-behavioral stress management techniques with adolescent boys. *Journal of Counseling and Development*, 70(5), 600-605. doi: 10.1002/j.1556-6676.1992.tb01668.x
- Halberstadt, A. G., Denham, S. A., Dunsmore, J. C. (2001). Affective social competence. *Social Development*; 10(1), 79–119. doi: 10.1111/1467-9507.00150

- Halford, K., & Foddy, M. (1982). Cognitive and social skills correlates of social anxiety. *British Journal of Clinical Psychology*, 21(1), 17-28.  
doi: 10.1111/j.2044-8260.1982.tb01422.x
- Hall, L. & Long, C.G. (2009). Back to basics: Progressive muscle relaxation (PMR) training for women detained in conditions of medium security. *Journal of Forensic Psychiatry & Psychology*, 20(3), 481-492.  
doi: 10.1080/14789940802638374
- Hamm, J. V. (2000). Do birds of a feather flock together? The variable bases for African American, Asian American, and European American adolescents' selection of similar friends. *Developmental Psychology*, 36(2), 209–219.  
doi: 10.1037//0012-1649.36.2.209
- Hammerness P, Harpold T, Petty C, Menard C, Zar-Kessler C, Biederman J. (2008). Characterizing non- OCD anxiety disorders in psychiatrically referred children and adolescents. *Journal of Affect Disorders*, 105(1-3), 213–219. doi:10.1016/j.jad.2007.05.012
- Han, Z. R., & Shaffer, A. (2013). The Relation of Parental Emotion Dysregulation to Children's Psychopathology Symptoms: The Moderating Role of Child Emotion Dysregulation. *Child Psychiatry and Human Development*, 44(5), 591–601. doi 10.1007/s10578-012-0353-7
- Hane, A. A., Fox, N. A., Henderson, H. A., & Marshall, P. J. (2008). Behavioral reactivity and approach-withdrawal bias in infancy. *Developmental Psychology*, 44(5), 1491–1496. doi: 10.1037/a0012855

- Hannesdottir, D. K. & Ollendick, T. H. (2007). The role of emotion regulation in the treatment of child anxiety disorders. *Clinical Child and Family Psychology Review*, 10(3), 275–293. doi 10.1007/s10567-007-0024-6
- Hardy, J. (2006). Speaking clearly: A critical review of the self-talk literature. *Psychology of Sport and Exercise*, 7, 81-97.  
doi:10.1016/j.psychsport.2005.04.002
- Hardy, J., Hall, C. R., Gibbs, C., & Greenslade, C. (2005). Self-talk and gross motor skill performance. *Athletic Insight: The Online Journal of Sport Psychology*. Available: <http://www.athleticinsight.com/Vol7Iss2/Self-TalkPerformance.htm>
- Hardy, J., Oliver, E., & Tod, D. (2009). A framework for the study and application of self-talk within sport. In S. Mellalieu, & S. Hanton (Eds.), *Advances in applied sport psychology. A review* (pp. 37-74). New York: Routledge.
- Harper, D.J. & Warner, S. J. (1993). Discourse, social constructionism and clinical psychology. *Changes* 11, 72–79.
- Harvey, A. G., Clark, D. M., Ehlers, A., & Rapee, R. M. (2000). Social anxiety and self-impression: cognitive preparation enhances the beneficial effects of video feedback following a stressful social task. *Behaviour Research and Therapy*, 38, 1183–1192. doi:10.1016/S0005-7967(99)00148-5
- Hatzigeorgiadis, A., Theodorakis, Y., & Zourbanos, N. (2004). Self-talk in the swimming pool: The effects of self-talk on thought content and

performance on water-polo tasks. *Journal of Applied Sport Psychology*, 16, 138-150. doi: 10.1080/10413200490437886

Hayward, C., Killen, J.D., Kraemer, H.C., Taylor, C.B. (1998). Linking Childhood Behavioral Inhibition to Adolescent Social Phobia: A Prospective Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1308-1316.  
doi: <http://dx.doi.org/10.1097/00004583-199812000-00015>

Hedman, E., Ström, P., Stükel, A., & Mörtberg, E. (2013). Shame and Guilt in Social Anxiety Disorder: Effects of Cognitive Behavior Therapy and Association with Social Anxiety and Depressive Symptoms. *PLoS ONE*, 8(4), e61713. doi:10.1371/journal.pone.0061713

Heeren, A., Reese, H. E., McNally, R. J., & Philippot, P. (2012). Attention training toward and away from threat in social phobia: effects on subjective, behavioral, and physiological measures of anxiety. *Behaviour Research and Therapy*, 50(1), 30-39. doi: 10.1016/j.brat.2011.10.005

Heimberg, R. G. (2002). Cognitive-behavioral therapy for social anxiety disorder: current status and future directions. *Biological psychiatry*, 51(1), 101–108. doi:10.1016/S0006-3223(01)01183-0

Heimberg, R. G., Brozovich, F. A., & Rapee, R. M. (2010). A cognitive-behavioral model of social anxiety disorder: update and extension. In S. G. Hofmann, & P. M. DiBartolo (Eds.), *Social anxiety: Clinical, developmental, and social perspectives* (2nd ed.). (pp. 395-422) New York: Academic Press.



- Heimberg, R. G., & Juster, H. R. (1995). Cognitive behavioral treatments: Literature review. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 261-309). New York: The Guilford Press.
- Heimberg, R. G., Liebowitz, M., Hope, D. A. & Schneier, F. (1995). Social Phobia: Diagnosis, Assessment and Treatment. New York: The Guildford Press.
- Henderson, L., & Zimbardo, P. (1998). Shyness. In *Encyclopedia of Mental Health*. San Diego, CA: Academic Press.
- Hermann, C., Ofer, J., & Flor, H. (2004). Covariation bias for ambiguous social stimuli in generalized social phobia. *Journal of Abnormal Psychology*, 113, 646–653. doi:10.1037/0021-843X.113.4.646
- Hessler, D. M., & Katz, L. F. (2007). Children's emotion regulation: Self-report and physiological response to peer provocation. *Developmental Psychology*, 43, 27-38. doi: 10.1037/0012-1649.43.1.27
- Hettema, J. M., Neale, M. C., & Kendler, K. S. (2001). A review and meta-analysis of the genetic epidemiology of anxiety disorders. *American Journal of Psychiatry*, 158 , 1568–1578.  
<http://dx.doi.org/10.1176/appi.ajp.158.10.1568>
- Hettema, J. J., Neale, M. C., Myers, J. M., Prescott, C. A., & Kendler, K. S. (2006). A population-based twin study of the relationship between neuroticism and internalizing disorders. *American Journal of Psychiatry*, 163(5), 857–864. doi: 10.1176/appi.ajp.163.5.857

- Higa, C. K. & Daleiden, E. L. (2008). Social anxiety and cognitive biases in non-referred children: the interaction of self-focused attention and threat interpretation biases. *Journal of Anxiety Disorders*, 22(3), 441–452. doi: 10.1016/j.janxdis.2007.05.005
- Higa, C. K., Phillips, L. K., Chorpita, B. F. & Daleiden, E. L. (2008). The structure of self-consciousness in children and young adolescents and relations to social anxiety. *Journal of Psychopathology and Behavioral Assessment*, 30(4), 261–271. doi 10.1007/s10862-008-9079-z
- Hilt, L. M., McLaughlin, K. A., & Nolen-Hoeksema, S. (2010). Examination of the response styles theory in a community sample of young adolescents. *Journal of Abnormal Child Psychology*, 38(4), 545–556. doi: 10.1007/s10802-009-9384-3
- Hinde, R. A., Easton, D. F., Meller, R. E., & Tamplin, A. M. (1983). Nature and determinants of preschoolers' differential behaviour to adults and peers. *British Journal of Developmental Psychology*, 1(1), 3-19. doi: 10.1111/j.2044-835X.1983.tb00540.x
- Hirsch C.R., Clark D.M. (2004). Information-processing bias in social phobia. *Clinical Psychology Review*, 24(7), 799–825. doi: 10.1016/j.cpr.2004.07.005
- Hirshfield, D., Biederman, J., Brody, L. (1997). Expressed emotion toward children with behavioral inhibition: Associations with maternal anxiety disorder. *Journal of the American Academy of Child & Adolescent*

*Psychiatry*, 36(7), 910-917. <http://dx.doi.org/10.1097/00004583-199707000-00012>

Hitchcock, C. A., Chavira, D. A., & Stein, M. B. (2009). Recent findings in social phobia among children and adolescents. *The Israel journal of psychiatry and related sciences*, 46(1), 34 -44.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: a review of qualitative studies. *Clinical Psychology and Psychotherapy*, 14(3), 157–163. doi: 10.1002/cpp.527

Hodson, K. J., McManus, F. V., Clark, D. M. & Doll, H. (2008). Can Clark and Wells' (1995) cognitive model of social phobia be applied to young people? *Behavioural and Cognitive Psychotherapy*, 36(4), 449–461. <http://dx.doi.org/10.1017/S1352465808004487>

Hofer, M. A. (1994). Hidden regulators in attachment, separation, and loss. *Monographs of the Society for Research in Child Development*, 59(2-3), 192–207. doi: 10.1111/j.1540-5834.1994.tb01285.x

Hofmann, S. G. (2000). Self-focused attention before and after treatment of social phobia. *Behaviour Research and Therapy*, 38(7), 717–725. doi:10.1016/S0005-7967(99)00105-9

Hofmann, S. G. (2004). Cognitive mediation of treatment change in social phobia. *Journal of Consulting and Clinical Psychology*, 72(3), 392-399. doi:10.1037/0022-006X.72.3.392

Hofmann, S. G. (2007). Cognitive factors that maintain social anxiety disorder:

A comprehensive model and its treatment implications. *Cognitive*

*Behaviour Therapy*, 36(4), 193-209. doi: 10.1080/16506070701421313

Hofmann, S.G. (2010). Recent advances in the psychosocial treatment of social

anxiety disorder. *Depression and Anxiety*, 27(12), 1073-1076.

doi: 10.1002/da.20771

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012a).

The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-

analyses. *Cognitive Therapy and Research*, 36(5), 427–440.

doi: 10.1007/s10608-012-9476-1

Hofmann, S. G., Gerlach, A. L., Wender, A., & Roth, W. T. (1997). Speech

disturbances and gaze behavior during public speaking in subtypes of  
social phobia. *Journal of Anxiety Disorders*, 11(6), 573–585.

doi:10.1016/S0887-6185(97)00040-6

Hofmann, S.G., Sawyer, A.T., Fang, A., & Asnaani, A. (2012b). An emotion

dysregulation model of anxiety and mood disorders. *Depression and*

*Anxiety*, 29(5), 409-416. doi: 10.1002/da.21888

Hofmann, S.G., Moscovitch, D.A., Kim, H.J., (2006). Autonomic correlates of

social anxiety and embarrassment in shy and non-shy individuals.

*International Journal of Psychophysiology* 61(2), 134–142.

doi:10.1016/j.ijpsycho.2005.09.003

Hofmann, S. G., & Roth, W. T. (1996). Issues related to social anxiety among controls in social phobia research. *Behavior Therapy*, 27(1), 79-91.  
doi:10.1016/S0005-7894(96)80037-2

Hofmann, W., Friese, M., & Strack, F. (2009). Impulse and self-control from a dual-systems perspective. *Perspectives on Psychological Science*, 4(2), 162–176. doi: 10.1111/j.1745-6924.2009.01116.x

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, 57(1), 285– 315. doi: 10.1146/annurev.psych.57.102904.190044

Hope, D. A., Heimberg, R. G., & Turk, C. L. (2006). *Therapist guide for managing social anxiety: A cognitive-behavioral therapy approach*. New York, NY: Oxford University Press.

Hopko, D.R., Robertson, S.M.C. & Lejuez, C.W. (2006). Behavioral activation for anxiety disorders. *The Behavior Analyst Today*, 7 (2), 212-232.  
<http://dx.doi.org/10.1037/h0100084>

Horley, K., Williams, L. M., Gonsalvez, C., & Gordon, E. (2004). Face to face: Visual scanpath evidence for abnormal processing of facial expressions in social phobia. *Psychiatry Research*, 127(1), 43–53.  
doi:10.1016/j.psychres.2004.02.016

Hoshmand, L.T. (2003). Can lessons of history and logical analysis ensure progress in psychological science? *Theory and Psychology*, 13(1), 39–44.  
doi: 10.1177/0959354303131003

- Howarth, G. Z., Guyer, A. E., & Perez-Edgar, K. (2013). Young children's affective responses to acceptance and rejection from peers: a computer-based task sensitive to variation in temperamental shyness and gender. *Social Development*, 22(1), 146–162. doi: 10.1111/sode.12006
- Hubbard, J. A., & Coie, J. D. (1994). Emotional correlates of social competence in children's peer relationships. *Merrill-Palmer Quarterly*, 40, 1-20.
- Hudson, J. L. (2005). Interparental conflict, violence, and psychopathology. In J. L. Hudson & R.M. Rapee (Eds.), *Psychopathology and the family* (pp. 53–72). Oxford: Elsevier.
- Hudson, J. L., & Rapee, R. M. (2001). Parent-child interactions and anxiety disorders: An observational study. *Behaviour Research and Therapy*, 39(12), 1411–1427. doi:10.1016/S0005-7967(00)00107-8
- Hudson, J. L., Rapee, R. M., Lyneham, H., Wuthrich, V., & Schneiring, C. A. (2010, June). *Treatment outcome for children with social phobia*. Paper presented at the World Congress of Behavioural and Cognitive Therapies, Boston, MA.
- Hughes, C., & Dunn, J. (1998). Understanding mind and emotion: longitudinal associations with mental-state talk between young friends. *Developmental Psychology*, 34(5), 1026–1037. doi:10.1037/0012-1649.34.5.1026
- Hughes, E. K. & Gullone, E. (2007). Internalizing symptoms and disorders in families of adolescents: A review of family systems literature. *Clinical Psychology Review* 28 (1): 92-117. doi:10.1016/j.cpr.2007.04.002

- Humphreys, K., Harris, A.H.S., Weingardt, K.R. (2008). Subject eligibility criteria can substantially influence the results of alcohol treatment outcome research. *Journal of Studies on Alcohol and Drugs*, 69 (5), 757-764.
- Huppert, F. A., Baylis, N., Kerverne, B. (Eds.), (2004). The Science of Well-Being: Integrating Neurobiology, Psychology and Social Science. Philos. Trans. R. Soc. London B: *Biol. Science*. 359, n 1449.
- In-Albon, T., Schneider, S. (2007). Psychotherapy of childhood anxiety disorders: a meta-analysis. *Psychotherapy Psychosom.* 76(1),15-24. doi: 10.1159/000096361
- Inderbitzen-Nolan, H. M., Anderson, E. R., & Johnson, H. S. (2007). Subjective versus objective behavioral ratings following two analogue tasks: a comparison of socially phobic and non-anxious adolescents. *Journal of Anxiety Disorders*, 21(1),76–90. doi: 10.1016/j.janxdis.2006.03.013
- Isen, A. M. (2000). Some perspectives on positive affect and self-regulation. *Psychological Inquiry*, 11(3), 184-187.
- Ishiyama, F. I. (1985). “Origins” of shyness: A preliminary survey on shyness-inducing critical experiences in childhood. B.C. Counsellor: *Journal of the British Columbia School Counsellors’ Association*, 7, 26–34.
- Izard C. E. (2002). Translating emotion theory and research into preventive interventions. *Psychological Bulletin*, 128(5), 796–824. doi:10.1037/0033-2909.128.5.796
- Izard C. E., King K. A., Trentacosta C. J., Laurenceau J. P., Morgan J. K. , Krauthamer-Ewing E. S., et al. (2008). Accelerating the development of

emotion competence in Head Start children: Effects on adaptive and maladaptive behaviour. *Development and Psychopathology*, 20(1), 369–397. doi: 10.1017/S0954579408000175

Izard, C. E., Woodburn, E. M., Finlon, K. J., Krauthamer-Ewing, E. S., Grossman, S. R., & Seidenfeld, A. (2011). Emotion knowledge, emotion utilization, and emotion regulation. *Emotion Review*, 3(1), 44-52. doi: 10.1177/1754073910380972

James, W. (1995, 1907). *Pragmatism*. New York: Dover.

Jarrett, R. B., Vittengl, J. R., Doyle, K., & Clark, L. A. (2007). Changes in cognitive content during and following cognitive therapy for recurrent depression: substantial and enduring, but not predictive of changes in depressive symptoms. *Journal of Consulting and Clinical Psychology*, 75(3), 432-446. doi: 10.1037/0022-006X.75.3.432

Jawaid, A., Schmolck, H., & Schulz, P. E. (2008). Hypersociability in Williams syndrome: A role for the amygdala? *Cognitive Neuropsychiatry*, 13(4), 338–342. doi:10.1080/13546800802243334

Joormann, J., & Gotlib, I. H. (2008). Updating the contents of working memory in depression: Interference from irrelevant negative material. *Journal of Abnormal Psychology*, 117(1), 182–192. doi: 10.1037/0021-843X.117.1.182

Joormann, I. H., & Gotlib, J. (2010). Cognition and depression: Current status and future directions. *Annual Review of Clinical Psychology*, 6, 285-312. doi: 10.1146/annurev.clinpsy.121208.131305



- Joormann, J., & Vanderlind, M. (2014). Emotion regulation in depression: The role of biased cognition and reduced cognitive control. *Clinical Psychological Science*, 2(4), 402–421. doi: 10.1177/2167702614536163
- John, O. P., & Gross, J. J. (2004). Healthy and unhealthy emotion regulation: Personality processes, individual differences, and life span development. *Journal of Personality*, 72(6), 1301-1334. doi: 10.1111/j.1467-6494.2004.00298.x
- Johnson, R. B., & Christensen, L. B. (2004). *Educational research: Quantitative, qualitative, and mixed approaches*. Boston, MA: Allyn and Bacon.
- Johnson, R. B., & Turner, L. A. (2003). Data collection strategies in mixed methods research. In A. Tashakkori, and C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 297–319). Thousand Oaks, CA: Sage.
- Johnson, R., & Onwuegbuzie, A. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*, 33(7), 14–26. doi: 10.3102/0013189X033007014
- Jones, S., Eisenberg, N., Fabes, R. A., & MacKinnon, D. P. (2002). Parents' reactions to elementary school children's negative emotions: Relations to social and emotional functioning at school. *Merrill - Palmer Quarterly*, 48, 133-159. doi: 10.1353/mpq.2002.0007

- Judd, L. L. (1995). Prevalence, lifecourse and disability in social phobia. *European neuropsychopharmacology* 5 (3): 224-225. doi:10.1016/0924-977X(95)90262-C
- Jurich, A. P., & Jurich, J. A. (1974). Correlations among nonverbal expressions of anxiety. *Psychological Reports*, 34, 199–204.  
doi:10.2466/pr0.1974.34.1.199
- Kagan, J., Reznick, J.S., & Snidman, N. (1987). The physiology and psychology of behavioral inhibition in children. *Child Development*, 58(6), 1459-1473.  
<http://dx.doi.org/10.2307/1130685>
- Kanai, Y., Sasagawa, S., Chen, J., Shimada, H., & Sakano, Y. (2009). Interpretation bias for ambiguous social behavior among individuals with high and low levels of social anxiety. *Cognitive Therapy and Research*, 2(34), 229-240. doi 10.1007/s10608-009-9273-7
- Kashdan, T. B. (2007). Social anxiety spectrum and diminished positive experiences: Theoretical synthesis and meta-analysis. *Clinical Psychol. Rev.*, 27(3), 348-365. doi:10.1016/j.cpr.2006.12.003
- Kashdan, T. B., & Breen, W. E. (2008). Social anxiety and positive emotions: A prospective examination of a self-regulatory model with emotion suppression and expression tendencies as moderators. *Behavior Therapy*, 39, 1-12. doi:10.1016/j.beth.2007.02.003
- Kashdan, T. B., & Collins, R. L. (2010). Social anxiety and the experience of positive emotion and anger in everyday life: an ecological momentary

assessment approach. *Anxiety, Stress & Coping*, 23(3), 259-272. doi:  
10.1080/10615800802641950

Kashdan, T. B., & Farmer, A. S. (2014). Differentiating Emotions Across  
Contexts: Comparing Adults With and Without Social Anxiety Disorder  
Using Random, Social Interaction, and Daily Experience Sampling.  
*Emotion*. Advance online publication. <http://dx.doi.org/10.1037/a0035796>

Kashdan, T. B., & Herbert, J. D. (2001). Social Anxiety disorder in childhood  
and adolescence: Current status and future directions. *Clinical Child and  
Family Psychology Review* 4(1), 37-61. doi: 10.1023/A:1009576610507

Kashdan, T. B., McKnight, P. E., Richey, J. A., & Hofmann, S. G. (2009). When  
social anxiety disorder co-exists with risk-prone, approach behavior:  
Investigating a neglected, meaningful subset of people in the National  
Comorbidity Survey-Replication. *Behaviour Research and Therapy*, 47(7),  
559-568. doi:10.1016/j.brat.2009.03.010

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a  
fundamental aspect of health. *Clinical Psychology Review*, 30(7), 865–878.  
doi:10.1016/j.cpr.2010.03.001

Kashdan, T. B., & Steger, M. F. (2006). Expanding the topography of social  
anxiety: An experience- sampling assessment of positive emotions,  
positive events, and emotion suppression. *Psychological Science*, 17(2),  
120-128. doi: 10.1111/j.1467-9280.2006.01674.x

Kashdan, T. B., Weeks, J. W., & Savostyanova, A. A. (2011). Whether, how, and  
when social anxiety shapes positive experiences and events: A self-

- regulatory framework and treatment implications. *Clinical Psychology Review*, 31(5), 786–799. doi:10.1016/j.cpr.2011.03.012
- Katz, L. F. & Low, S. M. (2004). Marital violence, co-parenting, and family-level processes in relation to children's adjustment. *Journal of Family Psychology* 18 (2), 372-382. doi:10.1037/0893-3200.18.2.372
- Keeley, M. L., & Storch, E. A. (2009). Anxiety disorders in youth. *Journal of pediatric nursing*, 24(1), 26–40. doi:10.1016/j.pedn.2007.08.021
- Keenan, K. (2000). Emotion dysregulation as a risk factor for child psychopathology. *Clinical Psychology: Science and Practice*, 7(4), 418 – 434. doi: 10.1093/clipsy.7.4.418
- Kelly, A. C., Zuroff, D. C., & Shapira, L. B. (2009). Soothing oneself and resisting self- attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognitive Therapy and Research*, 33(3), 301-313. doi 10.1007/s10608-008-9202-1
- Kemeny, M. E., Foltz, C., Cavanagh, J. F., Cullen, M., Giese-Davis, J., Jennings, P., Rosenberg E. L., Gillath, O., Shaver, P. R., Wallace, B. A., Ekman, P. (2012). Contemplative/emotion training reduces negative emotional behaviour and promotes prosocial responses. *Emotion*, 12(2), 338-350. doi: 10.1037/a0026118
- Kendall, P. C. (1990). Coping cat workbook. Ardmore, PA: Workbook Publishing.

- Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 62(1), 100–110. doi:10.1037/0022-006X.62.1.100
- Kendall, P. C. (2011). Anxiety disorders in youth. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioural procedures* (4th ed., pp. 143–189). New York: Guilford Press.
- Kendall, P. C., Aschenbrand, S. G., Hudson, J. L. (2003). Child-focused treatment of anxiety. In: Kazdin, AE.; Weisz, JR., editors. *Evidence-based psychotherapies for children and adolescents*. The Guilford Press; New York: p. 81-100.
- Kendall, P. C. & Choudhury, M. (2003). Children and adolescents in cognitive-behavioral therapy: Some past efforts and current advances, and the challenges in our future. *Cognitive Therapy and Research*, 27(1), 89-104. doi: 10.1023/A:1022542814822
- Kendall, P. C., Flannery-Schroeder, E., Panichelli-Mindel, S. M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 65 (3), 366-380. doi:10.1037/0022-006X.65.3.366
- Kendall, P. C., & Hedtke, K. (2006). Cognitive-Behavioral Therapy for anxious children: Therapist manual (3rd ed.). Ardmore, PA: Workbook.
- Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: outcomes in adolescence and impact on substance use

- and depression at 7.4-year-follow-up. *Journal of Consulting and Clinical Psychology*, 72 (2), 276–287. doi:10.1037/0022-006X.72.2.276
- Kendall, P. C., & Southam-Gerow, M. A. (1996). Long-term follow-up of a cognitive-behavioral therapy for anxiety-disordered youth. *Journal of Consulting and Clinical Psychology*, 64(4), 724–730. doi: 10.1037/0022-006X.64.4.724
- Kendall, P. C., & Treadwell, K. R. (2007). The role of self-statements as a mediator in treatment for youth with anxiety disorders. *Journal of Consulting and Clinical Psychology*, 75(3), 380-389. doi:10.1037/0022-006X.75.3.380
- Kendall, P. C., & Warman, M. (1996). Anxiety disorders youth: Diagnostic consistency across DSM-III-R and DSM-IV-R. *Journal of Anxiety Disorders*, 10(6), 453-463. doi:10.1016/S0887-6185(96)00022-9
- Kendler, K. S., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1992). Major depression and generalized anxiety disorder: Same genes, (partly) different environments? *Archives of General Psychiatry*, 49 (9), 716–722. doi:10.1001/archpsyc.1992.01820090044008
- Kerns, K. A., Klepac, L., & Cole, A. (1996). Peer relationships and preadolescents' perceptions of security in the child–mother relationship. *Developmental Psychology*, 32 (3), 457-466. doi:10.1037/0012-1649.32.3.457
- Kerns, C. M., Read, K. L., Klugman, J., & Kendall, P. C. (2013). Cognitive Behavioral Therapy for Youth with Social Anxiety: Differential Short and

- Long-Term Treatment Outcomes. *Journal of Anxiety Disorders*, 27 (2), 210-215. doi: 10.1016/j.janxdis.2013.01.009
- Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005a). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602. doi:10.1001/archpsyc.62.6.593.
- Kessler, R. C., Chiu, W., Demler, O., & Walters, E. E. (2005b). Prevalence, severity, and comorbidity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives Of General Psychiatry*, 62(6), 617-627. doi: 10.1001/archpsyc.62.6.617
- Khanna, M. S., & Kendall, P. C. (2009). Exploring the role of parent training in the treatment of childhood anxiety. *Journal of Consulting and Clinical Psychology*, 77 (5), 981-986. doi:10.1037/a0016920
- Kim, S.Y., & Oh, K. J. (2010). Information processing bias against emotional facial expressions in social anxiety. *Japanese Psychological Research*, 52(1), 23–32. doi: 10.1111/j.1468-5884.2009.00419.x
- King, G., Keohane, R. O. & Verba, S. (1994). *Designing Social Inquiry: Scientific Inference in Qualitative Research*. Princeton: Princeton University Press.
- Kirschenbaum, D. (1997). *Mind matters: 7 steps to smarter sport performance*. Carmel, Indiana: Cooper Publishing Group.
- Kiselica, M. S., Baker, S. B., Thomas, R. N., & Reedy, S. (1994). Effects of stress inoculation training on anxiety, stress, and academic performance

among adolescents. *Journal of Counselling Psychology*, 41 (3), 335-342.

doi:10.1037/0022-0167.41.3.335

Kley, H., Heinrichs, N., Bender, C., & Tuschen-Caffier, B. (2012). Predictors of outcome in a cognitive-behavioral group program for children and adolescents with social anxiety disorder. *Journal of anxiety disorders*, 26(1), 79–87. doi: 10.1016/j.janxdis.2011.09.002

Kley, H., Tuschen-Caffier, B., & Heinrichs, N. (2011). Safety behaviors, self-focused attention and negative thinking in children with social anxiety disorder, socially anxious and non-anxious children. *Journal of Behaviour Therapy and Experimental Psychiatry*, 43(1), 548–555. doi: 10.1016/j.jbtep.2011.07.008

Klimes-Dougan, B., Zeman, J. (2007). Introduction to the special issues of social development: emotion socialization in childhood and adolescence. *Social Development*, 16 (2), 203–209. DOI: 10.1111/j.1467-9507.2007.00380.x

Knappe, S., Beesdo-Baum, K., Fehm, L., Stein, M. B., Lieb, R., & Wittchen, H. U. (2011). Social fear and social phobia types among community youth: Differential clinical features and vulnerability factors. *Journal of Psychiatric Research*, 45(1), 111-120. doi:10.1016/j.jpsychires.2010.05.002

Koerner, N., Antony, M. M., Young, L., & McCabe, R. E. (2013). Changes in Beliefs about the Social Competence of Self and Others Following Group Cognitive-Behavioral Treatment. *Cognitive Therapy and Research*, 37, 256-265. doi: 10.1007/s10608-012-9472-5



- Kokkonen, M. & Pulkkinen, L. (1999). Emotion Regulation Strategies in Relation to Personality Characteristics Indicating Low and High Self-Control of Emotions. *Journal of Personality and Individual Differences*, 27(5), 913-932. doi: 10.1016/S0191-8869(99)00040-9
- Kolovelonis, A., Goudas, M., & Dermitzaki, I. (2010). The effects of instructional and motivational self-talk on students' motor task performance in physical education. *Psychology of Sport and Exercise*, 12(2), 153–158. doi:10.1016/j.psychsport.2010.09.002
- Kopp, C. B. (1989). Regulation of distress and negative emotions: a developmental view. *Developmental Psychology*, 25(3), 343-354. doi:10.1037/0012-1649.25.3.343
- Koole, S.L. (2009). The Psychology of Emotion Regulation: An Integrative Review. *Cognition & Emotion*, 23(1), 4 –41. doi: 10.1080/02699930802619031
- Kotsou, I., Nelis, D., Grégoire, J., Mikolajczak, M. (2011). Emotional plasticity: Conditions and effects of improving emotional competence in adulthood. *Journal of Applied Psychology*, 96 (4), 827-839. doi: 10.1037/a0023047
- Krantz M. (1982). Sociometric awareness, social participation, and perceived popularity in preschool children. *Child Development*; 53 (2), 376–379. <http://dx.doi.org/10.2307/1128979>
- Kremberg, E., Mitte, K. (2005). Kognitiv-behaviorale und behaviorale Interventionen der Sozialen Phobie im Kindes- und Jugendalter. *Zeitschrift für Klinische Psychologie und Psychotherapie*, 34, 196-204.

- Krohne, H. W. (1992). Developmental conditions of anxiety and coping: A two process model of child-rearing effects. In K. A. Hagtvet (Ed.) *Advances in test anxiety research*, Vol.7 (pp. 143–155). Lisse, The Netherlands: Swets & Zeitlinger.
- Krohne, H. W., & Hock, M. (1991). Relationships between restrictive mother-child interactions and anxiety of the child. *Anxiety Research*, 4(2), 109-124. doi: 10.1080/08917779108248768
- Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology*, 72(1), 3-18. doi:10.1037/0022-006X.72.1.3
- Kühl, S., Bender, C., Kley, H., Krämer, M., & Tuschen-Caffier, B. (2010). Prävention sozialer Angststörungen im Kindes- und Jugendalter: Notwendig oder überflüssig? *Verhaltenstherapie*, 20(4), 239–246. doi:10.1159/000321928
- Kulynych, J. (2001). No Playing in the Public Sphere: Democratic Theory and the Exclusion of Children. *Social Theory and Practice*, 27, (2), 231–264. doi: 10.5840/soctheorpract200127211
- LaFreniere, P., & Sroufe, L. A. (1985). Profiles of peer competence in the preschool: Interrelations between measures, influence of social ecology, and relation to attachment history. *Developmental Psychology*, 21(1), 56-69. doi: 10.1037/0012-1649.21.1.56

- La Greca, A. M., & Stone, W. L. (1993). Social Anxiety Scale for Children-Revised: Factor structure and concurrent validity. *Journal of Clinical Child Psychology*, 22(1), 17–27. doi: 10.1207/s15374424jccp2201\_2
- Laible, D. J., & Thompson, R. A. (1998). Attachment and emotional understanding in preschool children. *Developmental Psychology*, 34 (5), 1038-1045. doi:10.1037/0012-1649.34.5.1038
- Lane, A. M., Thelwell, R. C. Lowther, J., Devonport, T. J. (2009). Emotional intelligence and psychological skills use among athletes. *Behavior and Personality*, 37(2), 195-202. <http://dx.doi.org/10.2224/sbp.2009.37.2.195>
- Langer, J. K., & Rodebaugh, T. L. (2013). Social Anxiety and Gaze Avoidance: Averting Gaze but not Anxiety. *Cognitive Therapy and Research*, 37(6), 1110–1120. doi: 10.1007/s10608-013-9546-z
- Langley, A. K., Bergman, R. L., McCracken, J., & Piacentini, J. C. (2004). Impairment in childhood anxiety disorders: Preliminary examination of the child anxiety impact scale-parent version. *Journal of Child and Adolescent Psychopharmacology*, 14 (1), 105–114. doi:10.1089/104454604773840544
- Lansdown, G. (1994). Children's Rights, in B. Mayall (ed.) *Children's Childhoods Observed and Experienced*, pp. 33–44. London: Falmer Press.
- Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, 21(3), 318–337. doi:10.1177/0959354310377544

- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102–120. doi: 10.1191/1478088706qp062oa
- Larsen, R. J. (2000). Towards a science of mood regulation. *Psychological Enquiry*, 11, 129-141. doi:10.1207/S15327965PLI1103\_01
- Larson, R., & Richards, M. H. (1991). Daily companionship in late childhood and early adolescence: Changing developmental contexts. *Child Development*, 62 (2), 284-300. doi: 10.2307/1131003
- Last, C. G., Perrin, S., Hersen, M., & Kazdin, A. E. (1992). DSM-III-R anxiety disorders in children: sociodemographic and clinical characteristics. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31(6), 1070-1076. <http://dx.doi.org/10.1097/00004583-199211000-00012>
- Laurent, J., Catanzaro, S., Joiner, T., Rudolph, K., Potter, K., Lambert, S., et al. (1999). A measure of positive and negative affect for children: Scale development and preliminary validation. *Psychological Assessment*, 11(3), 326-338. doi:10.1037/1040-3590.11.3.326
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY, USA: Springer.
- Lecrubier, Y. & Weiller, E. (1997). Comorbidities in social phobia. *International Clinical Psychopharmacology*, 12, S17-S21.

- Leerkes, E. M., Paradise, M., O'Brien, M., Calkins, S. D., Lange, G. (2008).  
Emotion and Cognition Processes in Preschool Children. *Merrill-Palmer Quarterly*, 54(1), 102-124. doi: 10.1353/mpq.2008.0009
- Lester, K. J., Field, A. D., Oliver, S., & Cartwright-Hatton, S. (2009). Do  
anxious parents interpretive biases towards threat extend into their child's  
environment? *Behaviour Research and Therapy*, 47(2), 170-174.  
doi:10.1016/j.brat.2008.11.005
- Leone, D. R., Ray, S. L., & Evans, M. (2013). The Lived Experience of Anxiety  
Among Late Adolescents During High School: An Interpretive  
Phenomenological Inquiry. *Journal of Holistic Nursing : Official Journal  
of the American Holistic Nurses' Association*, 31 (3), 198-199.  
doi: 10.1177/0898010113501289
- Lewin, M. R., McNeil, D. R., & Lipson, J. M. (1996). Enduring without  
avoiding: Pauses and verbal dysfluencies in public speaking fear. *Journal  
of Psychopathology and Behavioral Assessment*, 18(4), 387-402. doi:  
10.1007/BF02229142
- Lewinsohn, P. M., Zinbarg, R., Seeley, J. R., Lewinsohn, M., & Sack, W. H.  
(1997). Life- time comorbidity among anxiety disorders and between  
anxiety disorders and other mental disorders in adolescents. *Journal of  
Anxiety Disorders*, 11 (4), 377-394. doi:10.1016/S0887-6185(97)00017-0
- Lieb, R., Wittchen, H-U., Hofler, M., Fuetsch, M., Stein, M. B., & Merikangas,  
K. R. (2000). Parental psychopathology, parenting styles, and the risk of  
social phobia in offspring: A prospective-longitudinal community study.

*Archives of General Psychiatry*, 57, 859–866.

doi:10.1001/archpsyc.57.9.859

Lieberman, M., Doyle, A., & Markiewicz, D. (1999). Developmental patterns in security of attachment to mother and father in late childhood and early adolescence: Associations with peer relations. *Child Development*, 70(1), 202 – 213. doi: 10.1111/1467-8624.00015

Lindahl, K., & Markman, H. J. (1990). Communication and negative affect regulation in the family. In E. Blechman (Ed.), *Emotions and families* (pp. 99–116). New York: Plenum Press.

Lock, S., & Barrett, P. M. (2003). A longitudinal study of developmental differences in universal preventive intervention for child anxiety. *Behaviour Change*, 20(4), 183–199.  
<http://dx.doi.org/10.1375/bech.20.4.183.29383>

Lonigan, C. J., Hooe, E. S., David, C. F., & Kistner, J.A. (1999). Positive and negative affectivity in children: Confirmatory factor analysis of a two-factor model and its relation to symptoms of anxiety and depression. *Journal of Consulting and Clinical Psychology*, 67 (3), 374-386.  
doi:10.1037/0022-006X.67.3.374

Lorig, K.R., & Holman, H.R. (2003). Self-management education: History, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine*, 26(1):1-7. doi: 10.1207/S15324796ABM2601\_01

- Losoya, S., Eisenberg, N., & Fabes, R. A. (1998). Developmental issues in the study of coping. *International Journal of Behavioral Development*, 22(2), 287-313. doi: 10.1080/016502598384388
- Lowry-Webster, H. M., Barrett, P. M., & Dadds, M. R. (2001). A universal prevention trial of anxiety and depressive symptomatology in childhood: Preliminary data from an Australian study. *Behaviour Change*, 18(1), 36–50. doi:10.1375/behc.18.1.36
- Lowry-Webster, H. M., Barrett, P. M., & Lock, S. (2003). A universal prevention trial of anxiety symptomatology during childhood: Results at 1-year follow-up. *Behaviour Change*, 20(1), 25–43. doi:10.1375/behc.20.1.25.24843
- Lucini, D., Norbiato, G., Clerici, M. & Pagani, M. (2002). Hemodynamic and autonomic adjustments to real life stress conditions in humans. *Hypertension*, 39(1), 184–188. doi: 10.1161/hy0102.100784
- Maag, J.W. (2005). Social skills training for youth with emotional and behavioral disorders and learning disabilities: *Problems, conclusions, and suggestions*. *Exceptionality*, 13, 155-172. doi: 10.1207/s15327035ex1303\_2
- MacDermott, S. T., Gullone, E., Allen, J. S., King, N. J., & Tonge, B. (2009). The Emotion Regulation Index for Children and Adolescents (ERICA): A Psychometric Investigation. *Journal of Psychopathology and Behavioral Assessment*, 32(3), 301–314. doi: 10.1007/s10862-009-9154-0

- Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8*(4), 325-337. doi:10.1080/09638239917256
- McLoone, J., Hudson, J. L., & Rapee, R. M. (2006). Treating anxiety disorders in a school setting. *Education & Treatment of Children, 29*(2), 219-242.
- McNaughton, N., & Gray, J. A. (2000). Anxiolytic action on the behavioural inhibition system implies multiple types of arousal contribute to anxiety. *Journal of Affective Disorders, 61*(3), 161–176. doi:10.1016/S0165-0327(00)00344-X
- McNeil, D. W., Ries, B. J., & Turk, C. L. (1995). Behavioral assessment: self-report, physiology, and overt behavior. In: R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: diagnosis, assessment, and treatment* (pp. 202–231). New York: Guilford.
- Magar, E. C. E., Phillips, L. H., & Hosie, J. A. (2008). Self-Regulation and risk-taking. *Personality and Individual Differences, 45*(2), 153-159. doi:10.1016/j.paid.2008.03.014
- Magee, W. J., Eaton, W. W., Wittchen, H. U., McGonagle, K. A. & Kessler, R. C. (1996). Agoraphobia, simple phobia, and social phobia in the National Comorbidity Survey. *Archives of General Psychiatry 53*(2), 159-168. doi:10.1001/archpsyc.1996.01830020077009
- Mahone, E. M., Bruch, M. A., & Heimberg, R. G. (1993). Focus of attention and social anxiety: The role of negative self-thoughts and perceived positive



attributes of the other. *Cognitive Therapy and Research*, 17(3), 209–224.

doi: 10.1007/BF01172946

Mallott, M., Maner, J. K., DeWall, C. N., & Schmidt, N. B. (2009).

Compensatory deficits following rejection: The role of social anxiety in disrupting affiliative behavior. *Depression and Anxiety*, 26(5), 438–446.

doi: 10.1002/da.20555

Manassis, K., Hudson, J. L., Webb, A., & Albano, A. (2004). Beyond

behavioural inhibition: Etiological factors in childhood anxiety. *Cognitive and Behavioural Practice* 11: 3-12. doi: 10.1016/S1077-7229(04)80003-8

Mancini, C., Van Ameringen, M., Szatmari, P., Fugere, C., et al. (1996). A high-

risk pilot study of the children of adults with social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(11), 1511–

1517. <http://dx.doi.org/10.1097/00004583-199611000-00020>

Marcks, B. A., & Woods, D. W. (2005). A comparison of thought suppression to

an acceptance-based technique in the management of personal intrusive thoughts: a controlled evaluation. *Behaviour Research and Therapy*, 43,

433–445. doi:10.1016/j.brat.2004.03.005

Marks, D.F. & Yardley, L. (eds) (2004). *Research Methods for Clinical and*

*Health Psychology*. London: Sage.

Martini, T. S., & Busseri, M. A. (2010). Emotion regulation strategies and goals

as predictors of older mothers' and adult daughters' helping-related

subjective well-being. *Psychology and Aging*, 25(1), 48-59. doi:

10.1037/a0018776

- Martinsen, K. D., Kendall, P. C., Stark, K., & Neumer, S.-P. (2014). Prevention of Anxiety and Depression in Children: Acceptability and Feasibility of the Transdiagnostic EMOTION Program. *Cognitive and Behavioral Practice* 2014. <http://dx.doi.org/10.1016/j.cbpra.2014.06.005>
- Masia, C. L., Klein, R. G., Storch, E. A., & Corda, B. (2001). School- based behavioral treatment for social anxiety disorder in adolescents: Results of a pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(7), 780–786. <http://dx.doi.org/10.1097/00004583-200107000-00012>
- Masia, C. L., & Morris, T. L. (1998). Parental factors associated with social anxiety: Methodological limitations and suggestions for integrated behavioral research. *Clinical Psychology: Science and Practice*, 5(2), 211–228. doi: 10.1111/j.1468-2850.1998.tb00144.x
- Masia-Warner, C., Klein, R. G., Dent, H. C., Fisher, P. H., Alvir, J., Albano, A. M., & Guardino, M. (2005). School-based intervention for adolescents with social anxiety disorder: results of a controlled study. *Journal of abnormal child psychology*, 33(6), 707–722. doi: 10.1007/s10802-005-7649-z
- Masia-Warner, C., Nangle, D.W., & Hansen, D. J. (2006). Bringing evidence-based child mental health services to the schools: General issues and specific populations. *Education and Treatment of Children*, 29(2), 165–172. Available at: [http://works.bepress.com/david\\_hansen1/7](http://works.bepress.com/david_hansen1/7)

- Matthews, B. L., Kerns, K. A., Ciesla, J. A. (2014). Specificity of emotions regulation difficulties related to anxiety in early adolescence. *Journal of Adolescence*, 37(7), 1089-1097. doi: 10.1016/j.adolescence.2014.08.002
- Maughan, A., Cicchetti, D. (2002). Impact of child maltreatment and interadult violence on children's emotion regulation abilities and socioemotional adjustment. *Child Development*, 73(5), 1525–1542. doi: 10.1111/1467-8624.00488
- Maxcy, S. J. (2003). Pragmatic threads in mixed methods research in the social sciences: The search for multiple modes of inquiry and the end of the philosophy of formalism. In A.Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 51–89). Thousand Oaks, CA: Sage.
- McCaffery, M., & Pasero, C. (1999). *Pain clinical manual*. (2nd ed). St.Louis: Mosby Year-Book.
- McCarty, C. A., Weisz, J. R., Wanitromanee, K., Eastman, K. L., Suwanlert, S., Chaiyasit, W., & Band, E. B. (1999). Culture, coping, and context: primary and secondary control among Thai and American youth. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40(5), 809–818. doi: 10.1111/1469-7610.00496
- McClure E. B., Nowicki S. (2001). Associations between social anxiety and nonverbal processing skill in preadolescent boys and girls. *Journal of Nonverbal Behaviour*; 25(1), 3–19. doi: 10.1023/A:1006753006870

- McCoy, C. L., & Masters, J. C. (1985). The development of children's strategies for the social control of emotion. *Child Development*, 56(5), 1214–1222. doi: 10.1111/j.1467-8624.1985.tb00190.x
- McCoy, D. C., & Raver, C. C. (2011). Caregiver Emotional Expressiveness, Child Emotion Regulation, and Child Behavior Problems among Head Start Families. *Social Development*, 20(4), 741–761. doi: 10.1111/j.1467-9507.2011.00608.x
- McEvoy, P.M., Nathan, P., Rapee, R.M., Campbell, B. (2012). Cognitive behavioural group therapy for social phobia: Evidence of Transportability to community clinics, *Behaviour Research and Therapy*, 50(4), 258-265. doi: 10.1016/j.brat.2012.01.009
- McLaughlin, K. A., & Hatzenbuehler, M. L. (2009). Mechanisms linking stressful life events and mental health problems in a prospective, community-based sample of adolescents. *Journal of Adolescent Health*, 44(2), 153–160. doi:10.1016/j.jadohealth.2008.06.019
- McLaughlin, K., & Hatzenbuehler, M. (2011). Emotion Dysregulation and Adolescent Psychopathology: A Prospective Study. *Research and Therapy*, 49(9), 544–554. doi: 10.1016/j.brat.2011.06.003
- McLaughlin, K. A., Mennin, D. S., & Farach, F. J. (2007). The contributory role of worry in emotion generation and dysregulation in generalized anxiety disorder. *Behaviour Research and Therapy*, 45(8), 1735–1752. doi: 10.1016/j.brat.2006.12.004

- McLeod, J. (2003). *An Introduction to Counselling*. 3<sup>rd</sup> edn. Buckingham. Open University Press.
- McLeod, B.D., Wood, J.J., Weisz, J.R. (2007). Examining the association between parenting and childhood anxiety: a meta-analysis. *Clinical Psychol Rev*, 27, 155-172. doi:10.1016/j.cpr.2006.09.002
- McManus, F., Peerbhoy, D., Larkin, M., & Clark, D. M. (2010). Learning to change a way of being: An interpretative phenomenological perspective on cognitive therapy for social phobia. *Journal of Anxiety Disorders*, 24(6), 581-589. doi: 10.1016/j.janxdis.2010.03.018
- McNally Keehn, R. H., Lincoln, A. J., Brown, M. Z., & Chavira, D. a. (2013). The Coping Cat Program for Children with Anxiety and Autism Spectrum Disorder: A Pilot Randomized Controlled Trial. *Journal of Autism and Developmental Disorders*, 43(1), 57–67. doi: 10.1007/s10803-012-1541-9
- Meleshko, K. G., & Alden, L. E. (1993). Anxiety and self-disclosure: Toward a motivational model. *Journal of Personality and Social Psychology*, 64(6), 1000–1009. doi:10.1037/0022-3514.64.6.1000
- Melfsen, S., & Florin, I. (2002). Do socially anxious children show deficits in classifying facial expressions of emotions? *Journal of Nonverbal Behavior*, 26(2), 109-126. doi: 10.1023/A:1015665521371
- Melfsen, S., Osterlow, J., & Florin, I. (2000). Deliberate emotional expressions of socially anxious children and their mothers. *Journal of Anxiety Disorders*, 14(3), 249–261. doi:10.1016/S0887-6185(99)00037-7

- Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2000). *Mental Health of Children and Adolescents in Great Britain*. London: Stationery Office.
- Mennin, D. S. (2005). Emotion and the acceptance-based approaches to the anxiety disorders. In S. M. Orsillo & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 37–68). New York, NY, USA: Springer Science + Business Media.
- Mennin, D. S. (2006). Emotion regulation therapy: An integrative approach to treatment-resistant anxiety disorders. *Journal of Contemporary Psychotherapy*, 36(2), 95-105. doi: 10.1007/s10879-006-9012-2
- Mennin, D. S., & Fresco, D. M. (2009). Emotion regulation as an integrative framework for understanding and treating psychopathology. In A. M. Kring & D. M. Sloan (eds.), *Emotion Regulation in Psychopathology: A Transdiagnostic Approach to Etiology and Treatment* (pp. 356-379). New York: Guilford.
- Mennin, D. S., Heimberg, R. G., Turk, C. L., & Fresco, D. M. (2005). Preliminary evidence for an emotion dysregulation model of generalized anxiety disorder. *Behaviour Research and Therapy*, 43, 1281-1310. doi:10.1016/j.brat.2004.08.008
- Mennin, D. S., Holaway, R. M., Fresco, D. M., Moore, M. T., & Heimberg, R. G. (2007). Delineating components of emotion and its dysregulation in anxiety and mood psychopathology. *Behavior Therapy*, 38(3), 284-302. doi:10.1016/j.beth.2006.09.001

- Mennin, D. S., McLaughlin, K. A., & Flanagan, T. J. (2009). Emotion regulation deficits in generalized anxiety disorder, social anxiety disorder, and their co-occurrence. *Journal of Anxiety Disorders*, 23, 866-871.  
doi:10.1016/j.janxdis.2009.04.006
- Merikangas, K. R. (2005). Vulnerability factors for anxiety disorders in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America*, 14(4), 649–79. doi: 10.1016/j.chc.2005.06.005
- Merikangas, K. R., Dierker, L. C., & Szatmari, P. (1998). Psychopathology among offspring of parents with substance abuse and/or anxiety disorders: a high risk study. *Journal of Child Psychology and Psychiatry*, 39, 711–720.
- Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 980-989.  
doi: 10.1016/j.jaac.2010.05.017
- Michalski, J.H., Mishna, F., Worthington, C. & Cummings, R (2003). A multi-method impact evaluation of a therapeutic summer camp. *Child and Adolescent Social Work Journal*, 20(1), 53-76.  
doi: 10.1023/A:1021467503588

- Miers, A. C., Blöte, A. W., Bögels, S. M., & Westenberg, P. M. (2008). Interpretation bias and social anxiety in adolescents. *Journal of Anxiety Disorders*, 22(8), 1462–71. doi: 10.1016/j.janxdis.2008.02.010
- Miers, A. C., Blöte, A. W., & Westenberg, P. M. (2010). Peer perceptions of social skills in socially anxious and nonanxious adolescents. *Journal of Abnormal Child Psychology*, 38(1), 33–41. doi: 10.1007/s10802-009-9345-x
- Mihalca, A. M., & Tarnavska, Y. (2013). Cognitive Emotion Regulation Strategies and Social Functioning in Adolescents. *Procedia - Social and Behavioral Sciences*, 82(3), 574–579. doi:10.1016/j.sbspro.2013.06.312
- Mikolajczak, M. Nelis, D. & Hansenne, M. (2008). If You Can Regulate Sadness, You Can Probably Regulate Shame: Associations Between Trait Emotional Intelligence, Emotion Regulation and Coping Efficiency Across Discrete Emotions. *Personality and Individual Differences*, 44(6), 1356-1368. doi: 10.1016/j.paid.2007.12.004
- Miles, M.B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. ThousandOaks, CA: Sage.
- Mills, R. S. L., & Rubin, K. H. (1998). Are behavioural. both differentially associated and psychological control with childhood aggression and social withdrawal? *Canadian Journal of Behavioural Science*, 30(2), 132-136. doi:10.1037/h0085803



- Minde, K., Roy, J., Bezonsky, R., & Hashemi, A. (2010). The effectiveness of CBT in 3-7 year old anxious children: preliminary data. *Journal of the Canadian Academy of Child and Adolescent Psychiatry* 19 (2), 109–15.
- Misfud, C., & Rapee, R. M. (2005). Early intervention for childhood anxiety in a school setting: Outcomes for an economically disadvantaged population. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 996–1004. doi: 10.1097/01.chi.0000173294.13441.87
- Montagne, B., Schutters, S., Westenberg, H. G. M., van Honk, J., Kessels, R. P. C., & de Haan, E. H. F. (2009). Reduced sensitivity in the recognition of anger and disgust in social anxiety disorder. *Cognitive Neuropsychiatry*, 11(4), 389-401. doi: 10.1080/13546800444000254
- Moore, S. A., Zoellner, L. A., & Mollenholt, N. (2008). Are expressive suppression and cognitive reappraisal associated with stress-related symptoms? *Behaviour Research and Therapy*, 46(9), 993–1000. doi: 10.1016/j.brat.2008.05.001
- Moore, P. S., Whaley, S. E., & Sigman, M. (2004). Interactions between mothers and children: impacts of maternal and child anxiety. *Journal of Abnormal Psychology*, 113(3), 471-476. doi:10.1037/0021-843X.113.3.471
- Moos, R. H., & Holahan, C. J. (2003). Dispositional and contextual perspectives on coping: Toward an integrative framework. *Journal of Clinical Psychology*, 59(12), 1387–1403. doi: 10.1002/jclp.10229

- Morgan, D. L. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research*, 8(3), 362–376. doi: 10.1177/104973239800800307
- Morris, A. S., Silk, J. S., Steinberg, L., Myers, S. S., & Robinson, L. R. (2007). The Role of the Family Context in the Development of Emotion Regulation. *Social Development (Oxford, England)*, 16(2), 361–388. doi: 10.1111/j.1467-9507.2007.00389.x
- Morrison, A. S., & Heimberg, R. G. (2013). Social anxiety and social anxiety disorder. *Annual Review of Clinical Psychology*, 9, 249–274. doi: 10.1146/annurev-clinpsy-050212-185631
- Morrow, S. L. (2007). Qualitative Research in Counseling Psychology. *The Counseling Psychologist*, 35, (2), 209-235. doi: 10.1177/0011000006286990
- Moscovitch, D. A. (2009). What is the core fear in social phobia? A new model to facilitate individualized case conceptualization and treatment. *Cognitive and Behavioral Practice*, 16(2), 123- 134. doi:10.1016/j.cbpra.2008.04.002
- Moscovitch, D. A., & Hofmann, S. G. (2007). When ambiguity hurts: social standards moderate self-appraisals in generalized social phobia. *Behaviour Research and Therapy*, 45, 1039–1052. doi: 10.1016/j.brat.2006.07.008
- Moscovitch, D. A., Suvak, M. K., & Hofmann, S. G. (2010). Emotional response patterns during social threat in individuals with generalized social anxiety

- disorder and non-anxious controls. *Journal of Anxiety Disorders*, 24(7), 785–791. doi: 10.1016/j.janxdis.2010.05.013
- Moses, E. B., & Barlow, D. H. (2006). A new unified approach for emotional disorders based on emotion science. *Current Directions in Psychological Science*, 15(3), 146-150. doi: 10.1111/j.0963-7214.2006.00425.
- Mostert, J. & Loxton, H. (2008). Exploring the effectiveness of the FRIENDS program in reducing anxiety symptoms among South African Children. *Behaviour Change*, 25,85–96. doi:10.1375/behc.25.2.85
- Mostow A. J., Izard C. E., Fine S. E., Trentacosta C. J. (2002). Modelling emotional, cognitive, and behavioural predictors of peer acceptance. *Child Development*; 73(6), 1775–1787. doi: 10.1111/1467-8624.00505
- Moukheiber, A., Rautureau, G., Perez-Diaz, F., Soussignan, R., Dubal, S., Jouvent, R., et al. (2010). Gaze avoidance in social phobia: Objective measure and correlates. *Behavior Research and Therapy*, 48(2), 147–151. doi: 10.1016/j.brat.2009.09.012
- Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington: National Academy Press.
- Mulveen, R., & Hepworth, J. (2006). An interpretative phenomenological analysis of participation in a pro-anorexia internet site and its relationship with disorder eating. *Journal of Health Psychology*, 11(2), 283–296. doi: 10.1177/1359105306061187

- Mulvihill, C., Rivers, K. and Aggleton, P. (2000). A Qualitative Study Investigating the Views of Primary-Age Children and Parents on Physical Activity. *Health Education Journal* 59, (2), 166–179.  
doi: 10.1177/001789690005900206
- Muraven, M.R., & Baumeister, R.F. (2000). Self-regulation and depletion of limited resources: Does self-control resemble a muscle? *Psychological Bulletin*, 126(2), 247-259. doi: 10.1037//0033-2909.126.2.247
- Muris, P., & Field, A. P. (2011). The “normal” development of fear. In W. K. Silverman & A. P. Field (Eds.), *Anxiety disorders in children and adolescents* (2<sup>nd</sup> ed., pp. 76–89). Cambridge: Cambridge University Press.
- Muris, P., Huijding, J., Mayer, B., Remmerswaal, D., & Vreden, S. (2009). Ground control to Major Tom: experimental manipulation of anxiety-related interpretation bias by means of the ‘space odyssey’ paradigm and the effects on avoidance tendencies in children. *Journal of Anxiety Disorders*, 23(3), 333–340. doi: 10.1016/j.janxdis.2009.01.004
- Muris, P., Mayer, B., van Lint, C. & Hofman, S. (2008). Attentional control and psychopathological symptoms in children. *Personality and Individual Differences*, 44(7), 1495–1505. doi:10.1016/j.paid.2008.01.006
- Muris, P., Meesters, C., & Melick, M. (2002). Treatment of childhood anxiety disorders: A preliminary comparison between cognitive- behavioral group therapy and a psychological placebo intervention. *Journal of Behavior Therapy and Experimental Psychiatry*, 33(3-4), 143–158.  
doi:10.1016/S0005-7916(02)00025-3

- Murphy, B. C., Shepard, S. A., Eisenberg, N., & Fabes, R. A. (2004). Concurrent and Across Time Prediction of Young Adolescents' Social Functioning: The Role of Emotionality and Regulation. *Social Development, 13*(1), 56-86. doi: 10.1111/j.1467-9507.2004.00257.x
- Murray, L., Cooper, P., Creswell, C., Schofield, E., & Sack, C. (2007). The effects of maternal social phobia on mother-infant interactions and infant social responsiveness. *Journal of Child Psychology and Psychiatry, 48*(1), 45–52. doi: 10.1111/j.1469-7610.2006.01657.x
- Mychailyszyn, M. P., Beidas, R. S., Benjamin, C. L., Edmunds, J. M., Podell, J. L., Cohen, J. S., & Kendall, P. C. (2011). Assessing and treating child anxiety in schools. *Psychology in the Schools, 48*(3), 223-232. doi: 10.1002/pits.20548
- Mzarek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risk for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.
- Naragon-Gainey, K., Watson, D., & Markon, K. E. (2009). Differential relations of depression and social anxiety symptoms to the facets of extraversion/positive emotionality. *Journal of Abnormal Psychology, 118*(2), 299–310. doi: 10.1037/a0015637
- Nastasi, B. K., & Schensul, S. L. (Eds.). (2005). Contributions of qualitative research to the validity of intervention research. *Journal of School Psychology, 43*(3), 177–195. doi:10.1016/j.jsp.2005.04.003

- Nauta, M., Scholing, A., Emmelkamp, P.M.G., & Minderaa, R. B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of a cognitive parent training. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(11), 1270–1278. <http://dx.doi.org/10.1097/01.chi.0000085752.71002.93>
- Nelis, D., Quoidbach, J., Mikolajczak, M., & Hansenne, M. (2009). Increasing emotional intelligence: (How) is it possible? *Personality and Individual Differences*, 47, 36–41. doi:10.1016/j.paid.2009.01.046
- Nelson, E. C., Grant, J. D., Bucholz, K. K., Glowinski, A., Madden, P. A. F., Reich, W., et al. (2000). Social phobia in a population-based female adolescent twin sample: Co-morbidity and associated suicide-related symptoms. *Psychological Medicine*, 30 (4), 797–804. doi: 10.1017/S0033291799002275
- Nelson, E. E., & Guyer, A. E. (2011). The development of the ventral prefrontal cortex and social flexibility. *Developmental Cognitive Neuroscience*, 1(3), 233–245. doi: 10.1016/j.dcn.2011.01.002
- Neil, A. L., & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programmes for anxiety. *Clinical psychology review*, 29(3), 208–15. doi:10.1016/j.cpr.2009.01.002
- Newman, I., & Benz, C. R. (1998). *Qualitative-quantitative research methodology: Exploring the interactive continuum*. Carbondale, IL: Southern Illinois University Press.

- Nezlek, J. B., & Kuppens, P. (2008). Regulating positive and negative emotions in daily life. *Journal of Personality*, 76(3), 561-580. doi: 10.1111/j.1467-6494.2008.00496.x
- Niedenthal, P. M., Barsalou, L. W., Ric, F., & Krauth-Gruber, S. (2005). Embodiment in the aquisition and use of emotion knowledge. In L. Feldman Barret, P. M. Niedenthal, & P. Winkielman (eds.), *Emotion and Consciousness* (pp.21-50). New York: Guilford.
- Nightingale, D. & Cromby, J. (Eds) (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham: Open University Press.
- Nolen-Hoeksema, S. (2000). The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology*, 109(3), 504–511. doi: 101037/10021-843X.109.3.504
- Nolen-Hoeksema, S., & Morrow, J. (1991). A prospective study of depression and posttraumatic stress symptoms after a natural disaster: The 1989 Loma Prieta earthquake. *Journal of Personality and Social Psychology*, 61 (1), 115-121. doi:10.1037/0022-3514.61.1.115
- Norton, P. J., & Hope, D. A. (2001). Kernels of truth or disorted perceptions: self and observer ratings of social anxiety and performance. *Behavior Therapy*, 32(4), 765–786. doi: 10.1016/S0005-7894(01)80020-4
- Novick-Kline, P., Turk, C. L., Mennin, D. S., Hoyt, E. A., & Gallagher, C. L. (2005). Level of emotional awareness as a differentiating variable between

- individuals with and without generalized anxiety disorder. *Journal of Anxiety Disorders*, 19(5), 557-572. doi:10.1016/j.janxdis.2004.06.001
- Offord, D. R., Kraemer, H. C., Kazdin, A. E., Jensen, P. S., & Harrington, R. (1998). Lowering the burden of suffering from child psychiatric disorder: Trade-offs among clinical, targeted and universal interventions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(7), 686-694. <http://dx.doi.org/10.1097/00004583-199807000-00007>
- Oh, W., Rubin, K. H., Bowker, J. C., Booth-LaForce, C., Rose-Krasnor, L., Laursen, B. (2008). Trajectories of social withdrawal from middle childhood to early adolescence. *Journal of Abnormal Child Psychology*, 36(4), 553-566. doi: 10.1007/s10802-007-9199-z
- Ohayon, M. M., & Schatzberg, A. F. (2010). Social phobia and depression: Prevalence and comorbidity. *Journal of Psychosomatic Research*, 68(3), 235-243. doi:10.1016/j.jpsychores.2009.07.018
- Olatunji, B. O., Cisler, J. M., & Tolin, D. F. (2010). A meta-analysis of the influence of comorbidity on treatment outcome in the anxiety disorders. *Clinical psychology review*, 30(6), 642–54. doi: 10.1016/j.cpr.2010.04.008
- Olfson M., Guardino M., Struening E., Schneier F. R., Hellman F., Klein D. F. (2000). Barriers to the treatment of social anxiety. *American Journal of Psychiatry* 157(4), 521–527. doi: 10.1176/appi.ajp.157.4.521
- Ollendick, T.H. (2009). Social anxiety disorder in youth: An ecological-developmental analysis. In J. A. Mancini & K. A. Roberto (Eds.),



*Pathways of human development* (pp. 95–112). New York: Lexington Books.

Ollendick, T. H., & Benoit, K. E. (2012). A parent-child interactional model of social anxiety disorder in youth. *Clinical Child and Family Psychology Review, 15*(1), 81-91. doi: 10.1007/s10567-011-0108-1

Ollendick, T. H., Costa, N. M., & Benoit, K. E. (2010). Interpersonal processes and the anxiety disorders of childhood. In G. Beck (Ed.), *Interpersonal processes in the anxiety disorders: Implications for understanding psychopathology and treatment* (pp. 71–95). Washington, DC: American Psychiatric Association Books.

Ollendick, T. H., & Hirshfeld Becker, D. R. (2002). The developmental and psychopathology of social anxiety disorder. *Biological Psychiatry, 51*(1), 44–58. doi:10.1016/S0006-3223(01)01305-1

Ollendick, T. H., & Horsch, L. M. (2007). Fears in children and adolescents: Relations with child anxiety sensitivity, maternal overprotection, and maternal phobic anxiety. *Behavior Therapy, 38*, 402–411.

Onwuegbuzie, A. J., & Leech, N. L. (2005). On becoming a pragmatic researcher: The importance of combining quantitative and qualitative research methodologies. *International Journal of Social Research Methodology: Theory & Practice, 8*(5), 375-387. doi: 10.1080/13645570500402447

Oppenheim, D., Nir, A., Warren, S., & Emde, R. N. (1997). Emotion regulation in mother–child narrative co-construction: associations with children’s

narratives and adaptation. *Developmental Psychology*, 33 (2), 284-294.

doi:10.1037/0012-1649.33.2.284

Öst, L.G, (1987). Applied relaxation: Description of a coping technique and review of controlled studies. *Behaviour Research and Therapy*, 25(5), 397-409. doi:10.1016/0005-7967(87)90017-9

Östlund, U., Kidd, L., Wengström, Y., Rowa-Dewar, N. (2011) Combining qualitative and quantitative research within mixed method research designs: A methodological review. *International Journal of Nursing Studies*, 48, (3), 369-383. doi: 10.1016/j.ijnurstu.2010.10.005

Otta, E., Lira, B., Delevati, M., Cesar, O., & Pires, C. (1994). The effect of smiling and of head tilting on person perception. *Journal of Psychology*, 128(3), 323-331. doi: 10.1080/00223980.1994.9712736

O'Toole, M. S., Hougaard, E., & Mennin, D. S. (2012). Social anxiety and emotion knowledge: A meta-analysis. *Journal of Anxiety Disorders*, 27, (1), 98-108. doi:10.1016/j.janxdis.2012.09.005

Palmieri, P. A., Boden, M. T., & Berenbaum, H. (2009). Measuring clarity and attention to emotions. *Journal of Personality Assessment*, 91(6), 560-567. doi: 10.1080/00223890903228539

Parker, J. G., Rubin, K. H., Price, J. M., & DeRosier, M. E. (1995). Peer relationships, child development and adjustment: A developmental psychopathology. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental psychopathology* (pp. 96–161). New York: Wiley.

- Parrott, W. G. (1993). Beyond Hedonism: Motives for Inhibiting Good Moods and for Maintaining Bad Moods. In D. M. Wegner & J. W. Pennebaker (Eds.), *Handbook of mental control* (pp. 278-305). Englewood Cliffs, NJ: Prentice Hall.
- Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L.S.Wrightsman(Eds.), *Measures of personality and social psychological attitudes* (pp. 17–59). San Diego, CA: Academic Press.
- Pawlow, L., & Jones, G. (2002). The impact of abbreviated progressive muscle relaxation on salivary cortisol. *Biological Psychology*, 60(1), 1-16.  
doi:10.1016/S0301-0511(02)00010-8
- Payne, J. W., Bettman, J. R., & Johnson, E. J. (1993). *The adaptive decision maker*. New York, NY: Cambridge University Press.
- Perini, S. J., Abbott, M. J., & Rapee, R. M. (2006). Perception of performance as a mediator in the relationship between social anxiety and negative post-event rumination. *Cognitive Therapy and Research*, 30(5), 645-659.  
doi: 10.1007/s10608-006-9023-z
- Peterson, A., & Jenni, C. B. (2003). Men’s experience of making the decision to have their first child: A phenomenological analysis. *The Family Journal: Counselling and Therapy for Couples and Families*, 11(4), 353–363.  
doi: 10.1177/1066480703255787

- Pfeifer, J. H., & Peake, S. J. (2012). Self-development: integrating cognitive, socioemotional, and neuroimaging perspectives. *Developmental Cognitive Neuroscience*, 2(1), 55–69. doi:10.1016/j.dcn.2011.07.012
- Phillips, J. R. (1988). Research blenders. *Nursing Science Quarterly*, 1, 4–5.
- Plasencia, M. L., Alden, L. E., & Taylor, C. T. (2011). Differential effects of safety behaviour subtypes in social anxiety disorder. *Behaviour Research and Therapy*, 49(10), 665–675. doi: 10.1016/j.brat.2011.07.005
- Pollak, S. D., & Sinha, P. (2002). Effects of early experience on children's recognition of facial displays of emotion. *Developmental Psychology*, 38(5), 784–791. doi: 10.1037//0012-1649.38.5.784
- Pomerantz, E. M., Ruble, D. N., Frey, K. S., & Greulich, F. (1995). Meeting goals and confronting conflict: children's changing perceptions of social-comparison. *Child Development*, 66(3), 723–738. doi: 10.1111/j.1467-8624.1995.tb00901.x
- Pond, R. S., Kashdan, T. B., Dewall, C. N., Savostyanova, A., Lambert, N. M., & Fincham, F. D. (2012). Emotion differentiation moderates aggressive tendencies in angry people: A daily diary analysis. *Emotion*, 12(2), 326–337. doi: 10.1037/a0025762
- Ponniah, K., & Hollon, S. D. (2008). Empirically supported psychological interventions for social phobia in adults: A qualitative review of randomized controlled trials. *Psychological Medicine*, 38, 3-14. doi:10.1017/S0033291707000918

- Potter, J. (1996). Discourse analysis and constructionist approaches: theoretical background. In Richardson, J.T.E., editor, *Handbook of qualitative research methods for psychology and the social sciences*. Leicester: B.P.S. Books.
- Quoidbach, J., Berry, V. E., Hansenne, M., & Mikolajczak, M. (2010). Positive emotion regulation and well-being: Comparing the impact of eight savouring and dampening strategies. *Personality and Individual Differences*, 49(5), 368–373. doi:10.1016/j.paid.2010.03.048
- Rambaldo, L. R., Wilding, L. D., Goldman, M. L., McClure, J. M., & Friedberg, R. D. (2001). School-based interventions for anxious and depressed children. In L. VandeCreek, & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (pp. 347–358). Sarasota, FL: Professional Resource Press.
- Ramsden, S. R., & Hubbard, J. A. (2002). Family expressiveness and parental emotion coaching: Their role in children's emotion regulation and aggression. *Journal of Abnormal Child Psychology*, 30(6), 657–667. <http://dx.doi.org/10.1023/A:1020819915881>
- Ranta, K., Kaltiala-Heino, R., Rantanen, P., & Marttunen, M. (2009). Social phobia in Finnish general adolescent population: Prevalence, comorbidity, individual and family correlates, and service use. *Depression and Anxiety*, 26(6), 528–536. DOI: 10.1002/da.20422
- Rao, P. A., Beidel, D. C., Turner, S. M., Ammerman, R. T., Crosby, L. E., & Sallee, F. R. (2007). Social anxiety disorder in childhood and adolescence:

Descriptive psychopathology. *Behaviour Research and Therapy*, 45(6), 1181-1191. doi:10.1016/j.brat.2006.07.015

Rapee, R. M. (1995). *Descriptive psychopathology of social phobia*. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 41–66). New York: Guilford Press.

Rapee, R. M. (2000). Group treatment of children with anxiety disorders: outcome and predictors of treatment response. *Australian Journal of Psychology*, 52(3), 125–129. doi: 10.1080/00049530008255379

Rapee, R. M., & Abbott, M. J. (2007). Modelling relationships between cognitive variables during and following public speaking in participants with social phobia. *Behaviour Research and Therapy*, 45(12), 2977-2989. doi:10.1016/j.brat.2007.08.008

Rapee, R. M., Gaston, J. E., & Abbott, M. J. (2009a). Testing the efficacy of theoretically derived improvements in the treatment of social phobia. *Journal of Consulting and Clinical Psychology*, 77(2), 317-327. doi: 10.1037/a0014800.

Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioural model of anxiety in social phobia. *Behaviour Research and Therapy*, 35(8), 741–756. doi:10.1016/S0005-7967(97)00022-3

Rapee, R. M. & Lim, L. (1992). Discrepancy between self and observer ratings of performance in social phobics. *Journal of Abnormal Psychology* 101(4), 728-731. doi:10.1037/0021-843X.101.4.728

- Rapee, R. M., & Melville, L. F. (1997). Recall of family factors in social phobia and panic disorder: Comparison of mother and offspring reports. *Depression and Anxiety*, 5(1), 7-11. DOI: 10.1002/(SICI)1520-6394(1997)5:13.0.CO;2-E
- Rapee, R. M., Schniering, C. A., & Hudson, J. L. (2009b). Anxiety disorders during childhood and adolescence: Origins and treatment. *Annual Review of Clinical Psychology*, 5, 311–341. doi: 10.1146/annurev.clinpsy.032408.153628
- Rapee R. M., & Spence S. H. (2004). The etiology of social phobia: empirical evidence and an initial model. *Clinical Psychology Review*; 24(7), 737–767. doi:10.1016/j.cpr.2004.06.004
- Rausch, S. M., Gramling, S. E., & Auerbach, S. M. (2006). Effects of a single session of large-group meditation and progressive muscle relaxation training on stress reduction, reactivity, and recovery. *International Journal of Stress Management*, 13 (3), 273-290. doi:10.1037/1072-5245.13.3.273
- Reichardt, C. S. & Rallis, S. F. (1994). Qualitative and quantitative inquiries are not incompatible: A call for a new partnership. *New Directions for Program Evaluation*, 61, 85–91. doi: 10.1002/ev.1670
- Reid, A. J. (1996). What we want: Qualitative research. *Canadian Family Physician*, 42, 387–389.
- Reid, K. (2008). *Parenting behaviours, interpretational biases and social anxiety in adolescents* (Doctoral dissertation, University of Manchester).

- Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience: an introduction to interpretative phenomenological analysis. *Psychologist* 18, 20-23.
- Reivich, K., Gillham, J. E., Chaplin, T. M., & Seligman, M. E. P. (2005). From helplessness to optimism: The role of resilience in treating and preventing depression in youth. In S. Goldstein & R. B. Brooks (Eds.), *Handbook of resilience in children* (pp. 223–237). New York: Kluwer Academic/Plenum Publishers.
- Reijntjes, A., Stegge, H., Terwogt, M. M., Kamphuis, J. H., & Telch, M. J. (2006). Emotion regulation and its effects on mood improvement in response to an in vivo peer rejection challenge. *Emotion*, 6(4), 543–552.  
doi:10.1037/1528-3542.6.4.543
- Reuland, M. M., Teachman, B. A. (2014). Interpretation bias modification for youth and their parents: A novel treatment for early adolescent social anxiety. *Journal of Anxiety Disorders*, 28(8), 851-864. doi: 10.1016/j.janxdis.2014.09.011
- Rheingold, A. A., Herbert, J. D., & Franklin, M. E. (2003). Cognitive bias in adolescents with social anxiety disorder. *Cognitive Therapy and Research*, 27(6), 639-655. doi: 10.1023/A:1026399627766
- Richards, J. M., Butler, E. A., & Gross, J. J. (2003). Emotion regulation in romantic relationships: The cognitive consequences of concealing feelings. *Journal of Social and Personal Relationships*, 20(5), 599–620.  
doi: 10.1177/02654075030205002



- Richards, J. M., & Gross, J. J. (2000). Emotion regulation and memory: The cognitive costs of keeping one's cool. *Journal of Personality and Social Psychology*, 79 (3), 410-424. doi:10.1037/0022-3514.79.3.410
- Riso, L. P., du Toit, P. L., Stein, D. J., & Young, J. E. (Eds.). (2007). *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide*. Washington, DC: American Psychological Association.
- Robb, S. L. (2000). Music assisted progressive muscle relaxation, progressive muscle relaxation, music listening, and silence: A comparison on relaxation techniques. *Journal of Music Therapy*, 37(1), 2-21.  
doi: 10.1093/jmt/37.1.2
- Rodebaugh, T. L., Holaway, R. M., & Heimberg, R. G. (2004). The treatment of social anxiety disorder. *Clinical psychology review*, 24(7), 883–908.  
doi:10.1016/j.cpr.2004.07.007
- Roemer, L., Lee, J. K., Salters-Pednaeault, K., Erisman, S. M., Orsillo, S. M., & Mennin, D. S. (2009). Mindfulness and emotion regulation difficulties in generalized anxiety disorder: Preliminary evidence for independent and overlapping contributions. *Behavior Therapy*, 40(2), 142–154.  
doi: 10.1016/j.beth.2008.04.001
- Rosenberg, R., & Kosslyn, S. (2011). *Abnormal Psychology*. New York: Worth.
- Rossmann, B. B. R. (1992). School-age children's perception of coping with distress: strategies for emotion regulation and the moderation of adjustment. *Journal of Child Psychology and Psychiatry*, 33(8), 1373–1397. doi: 10.1111/j.1469-7610.1992.tb00957.x

- Rubin, K. H., Coplan, R. J., & Bowker, J. C. (2009). Social withdrawal in childhood. *Annual Review of Psychology*, 60, 141–171. doi: 10.1146/annurev.psych.60.110707.163642
- Rubin, K. H., Daniels-Beirness, T., & Bream, L. (1984). Social isolation and social problem solving: A longitudinal study. *Journal of Consulting and Clinical Psychology*, 52(1), 17–25. <http://dx.doi.org/10.1037/0022-006X.52.1.17>
- Rubin, K. H., Dwyer, K. M., Booth-LaForce, C., Kim, A. H., & Rose-Krasnor, L. (2004). Attachment, friendship, and psychosocial functioning in early adolescence. *Journal of Early Adolescence*, 24(4), 326–356. doi: 10.1177/0272431604268530
- Rubin, K. H., Nelson, L. J., Hastings, P., & Asendorpf, J. B. (1999). The Transaction between parents' perceptions of their children's shyness and their parenting styles. *International Journal of Behavioral Development*, 23(4), 937–957. doi: 10.1080/016502599383612
- Rubin, K.H., Stewart, S.L., & Coplan, R.J. (1995). Social withdrawal in childhood: Conceptual and empirical perspectives. *Advances in Clinical Child Psychology*, 17, 157–196. doi: 10.1007/978-1-4757-9044-3\_4
- Ruscio A, Brown T, Chiu W, Sareen J, Stein M, & Kessler R. (2008). Social fears and social phobia in the USA: results from the National Comorbidity Survey replication. *Psychological Medicine*, 38(1): 15-28. doi: 10.1017/S0033291707001699

- Russel, A., Pettit, G.S., & Mize, J. (1998). Horizontal qualities in parent-child relationships: Parallels with and possible consequences for children's peer relationships. *Developmental Review, 18*(3), 313-332.  
doi:10.1006/drev.1997.0466
- Rydell, A., Berlin, L., & Bohlin, G. (2003). Emotionality, emotion regulation, and adaptation among 5- to 8-year-old children. *Emotion, 3*(1), 30-47. doi: 10.1037/1528-3542.3.1.30
- Saarni, C. (1999). *The development of emotional competence*. New York: Guilford.
- Saarni, C., Mumme, D., & Campos, J.J. (1998). Emotional development: Action, communication, and understanding. In N. Eisenberg (Ed.), *Handbook of child psychology: Social, emotional and personality development* (pp. 237 – 309). New York: Wiley.
- Saavedra, L. M., Silverman, W. K., Morgan-Lopez, A. A., & Kurtines, W. M. (2010). Cognitive behavioral treatment for childhood anxiety disorders: Long-term effects on anxiety and secondary disorders in young adulthood. *Journal of Child Psychology and Psychiatry, 51*(8), 924-934.  
doi: 10.1111/j.1469-7610.2010.02242.x
- Safren, S. A., Heimberg, R. G., Brown, E. J. & Holle, C. (1996). Quality of life in social phobia. *Depression and Anxiety, 4*(3), 126-133.  
doi: 10.1002/(SICI)1520-6394(1996)4:3<126::AID-DA5>3.0.CO;2-E

- Sale, J., Lohfeld, L., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality and Quantity*, 36(1), 43–53. doi: 10.1023/A:1014301607592
- Salemink, E., & Wiers, R. W. (2011). Modifying threat-related interpretive bias in adolescents. *Journal of Abnormal Child Psychology*, 39(7), 967–976. doi: 10.1007/s10802-011-9523-5
- Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination Cognition and Personality*, 9, 185-211. doi:0.2190/DUGG-P24E-52WK-6CDG
- Salovey, P., Mayer, J. D., Goldman, S., Turvey, C., & Palfai, T. (1995). *Emotional attention, clarity, and repair: Exploring emotional intelligence using the Trait Meta-Mood Scale*. In J. W. Pennebaker (Ed.), *Emotion, disclosure, and health* (pp. 125-154). Washington, D.C.: American Psychological Association.
- Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. *Research in Nursing & Health*, 23(3), 246–255. doi: 10.1002/1098-240X(200006)23:3<246::AID-NUR9>3.0.CO;2-H
- Scharfstein, L., Alfano, C., Beidel, D., & Wong, N. (2011). Children with generalized anxiety disorder do not have peer problems, just fewer friends. *Child Psychiatry and Human Development*, 42(6), 712–723. doi: 10.1007/s10578-011-0245-2

- Schneider, B.H. (2009). An observational study of the interactions of socially withdrawn/ anxious early adolescents and their friends. *Journal of Child Psychology and Psychiatry* 50(7), 799–806. doi: 10.1111/j.1469-7610.2008.02056.x
- Schlenker, B., & Leary, M. (1982). Social anxiety and self-presentation: A conceptualization and model. *Psychological Bulletin*, 92(3), 641-669. <http://dx.doi.org/10.1037/0033-2909.92.3.641>
- Schmitz, J., Krämer, M., Blechert, J., & Tuschen-Caffier, B. (2010). Post-event processing in children with social phobia. *Journal of Abnormal Child Psychology*, 38(7), 911–919. doi: 10.1007/s10802-010-9421-2
- Schneier, F. R., Johnson, J., Hornig, C. D., Liebowitz, M. R., & Weissman, M. M. (1992). Social phobia – comorbidity and morbidity in an epidemiologic sample. *Archives of General Psychiatry*, 49(4), 282-288. doi:10.1001/archpsyc.1992.01820040034004
- Schneier, F. R., Rodebaugh, T. L., Blanco, C., Lewin, H., & Liebowitz, M. R. (2011). Fear and avoidance of eye contact in social anxiety disorder. *Comprehensive Psychiatry*, 52(1), 81–87. doi:10.1016/j.comppsy.2010.04.006
- Schofield, C. A., Coles, M. E., & Gibb, B. E. (2007). Social anxiety and interpretation biases for facial displays of emotion: emotion detection and ratings of social cost. *Behaviour Research and Therapy*, 45(12), 2950-2963. doi: 10.1016/j.brat.2007.08.006

- Schultz, D., Izard, C. A., Ackerman, B. P., & Youngstrom, E. A. (2001). Emotion knowledge in economically disadvantaged children: Self-regulatory antecedents and relations to social difficulties and withdrawal. *Development and Psychopathology*, 13(1), 53-67.  
doi: 10.1017/S0954579401001043
- Schultz, D., Izard, C. E., & Bear, G. (2004). Children's emotion processing: Relations to emotionality and aggression. *Development and Psychopathology*, 16, 371–387. doi: 10.10170S0954579404044566
- Schutte, N.S., Manes, R.R., & Malouff, J.M. (2009). Antecedent-focused emotion regulation, response modulation and well-being. *Current Psychology*, 28(1), 21-31. doi: 10.1007/s12144-009-9044-3
- Scott, J. (2000) 'Children as Respondents: The Challenge for Qualitative Researchers', in P. Christensen and A. James (eds) *Research with Children: Perspectives and Practices*, pp. 98–119. London: Falmer Press.
- Sebastian, C., Burnett, S., & Blakemore, S. J. (2008). Development of the self-concept during adolescence. *Trends in Cognitive Science*, 12(11), 441–446.  
doi: 10.1016/j.tics.2008.07.008.
- Sechrest, L., & Sidana, S. (1995). Quantitative and qualitative methods: Is there an alternative? *Evaluation and Program Planning*, 18(1), 77–87.  
doi:10.1016/0149-7189(94)00051-X
- Secker, J., Wimbush, E., Watson, J. & Milburn, K. (1995). Qualitative methods in health promotion research: Some criteria for quality. *Health Education Journal*, 54(1), 74–87. doi: 10.1177/001789699505400108

- Seligman, L. D., Goza, A. B., & Ollendick, T. H. (2004). Treatment of depression in children and adolescents. In T. H. Ollendick & P. Barrett (Eds.), *Handbook of interventions that work with children and adolescents: From prevention to treatment* (pp. 301–328). London: Wiley.
- Seligman, L. D., & Ollendick, T. H. (2011). Cognitive behavior therapy for anxiety disorders in children and adolescents. *Psychiatric Clinics of North America*, 20(2), 217–238. doi:10.1016/j.chc.2011.01.003
- Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *The American Psychologist*, 60(5), 410-421. doi: 10.1037/0003-066X.60.5.410
- Settipani, C. a, & Kendall, P. C. (2012). Social Functioning in Youth with Anxiety Disorders: Association with Anxiety Severity and Outcomes from Cognitive-Behavioral Therapy. *Child Psychiatry and Human Development*, 44(1), 1-18. doi: 10.1007/s10578-012-0307-0
- Sheppes, G., Catran, E., & Meiran, N. (2009). Reappraisal (but not distraction) is going to make you seat: physiological evidence for self control effort. *International Journal of Psychophysiology*, 71(2), 91-96. doi:10.1016/j.ijpsycho.2008.06.006
- Sheldon, B. (2011). Cognitive-behavioural-therapy: research and practice in health and social care. Routledge: Oxon.
- Sheldon, K., & Ryan, R., Rawsthorne, L., & Ilardi, B. (1997). Trait self and true self: Cross-role variation in the Big-Five personality traits and its relations with psychological authenticity and subjective well-being. *Journal of*

*Personality and Social Psychology*, 73(6), 1380–1393. doi:10.1037/0022-3514.73.6.1380

Sheu, S., Irvin, B.L., Lin, H.S., & Mar C.L. (2003). Effects of progressive muscle relaxation on blood pressure and psychosocial status for clients with essential hypertension in Taiwan. *Holist Nursing Practice*, 17(1), 41-7. doi: 10.1097/00004650-200301000-00009

Shields, A., & Cicchetti, D. (1997). Emotion regulation among school-age children: the development and validation of a new criterion Q-sort scale. *Developmental Psychology*, 33(6), 906-916. doi:10.1037/0012-1649.33.6.906

Shields, A., & Cicchetti, D. (1998). Reactive aggression among maltreated children: The contributions of attention and emotion dysregulation. *Journal of Clinical Child Psychology*, 27(4), 381-395. doi: 10.1207/s15374424jccp2704\_2

Shonkoff, J. P., & Philipps, D. A. (Eds.). (2000). *From neurons to neighborhoods*. Washington, DC: National Academy Press.

Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child and Adolescent Psychology*, 30, 525–535. doi: 10.1207/S15374424JCCP3004\_09

Silk, J. S., Shaw, D. S., Skuban, E. M., Olan, A.A., Kovacs, M. (2006). Emotion regulation strategies in offspring of childhood-onset depressed mothers.



*Journal of Child Psychology Psychiatry*, 47(1), 69–78.

doi: 10.1111/j.1469-7610.2005.01440.x

Silk, J. S., Steinberg, L., & Morris, A. S. (2003). Adolescents' emotion regulation in daily life: Links to depressive symptoms and problem behaviours. *Child Development*, 74(6), 1869-1880. doi: 10.1046/j.1467-8624.2003.00643.x

Silk, J. S., Vanderbilt-Adriance, E., Shaw, D. S., Forbes, E. E., Whalen, D. J., Ryan, N. D., & Dahl, R. (2007). Resilience among children and adolescents at risk for depression: Mediation and moderation across social and neurobiological context. *Development and Psychopathology*, 19, 841-865. doi: 10.1017/S0954579407000417

Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Lumpkin, P. W., & Carmichael, D. H. (1999). Treating anxiety disorders in children with group cognitive-behavioral therapy: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 67(6), 995-1003. doi:10.1037/0022-006X.67.6.995

Silverman, W. K., Kurtines, W. M., Jaccard, J., & Pina, A. A. (2009). Directionality of change in youth anxiety treatment involving parents: An initial examination. *Journal of Consulting and Clinical Psychology*, 77(3), 474–485. doi: 10.1037/a0015761

Silverman, W. K., Pina, A. a, & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of clinical child and adolescent psychology : the*

*official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 37(1), 105–30. doi: 10.1080/15374410701817907*

Silvers, J. A., McRae, K., Gabrieli, J. D., Gross, J. J., Remy, K. A., & Ochsner, K. N. (2012). Age-related differences in emotional reactivity, regulation, and rejection sensitivity in adolescence. *Emotion, 12*(6), 1235–1247. doi: 10.1037/a0028297

Sim, L., & Zeman, J. (2005). Emotion regulation factors as mediators between body dissatisfaction and bulimic symptoms in early adolescent girls. *Journal of Early Adolescence, 25*(4), 478-496. doi: 10.1177/0272431605279838

Sim, L., & Zeman, J. (2006). The contribution of emotion regulation to body dissatisfaction and disordered eating in early adolescent girls. *Journal of Youth and Adolescence, 35*(2), 207- 216. doi: 10.1007/s10964-005-9003-8

Simpson, D., Suárez, L., Connolly, S. (2012). Treatment and Outcomes for Anxiety Disorders among Children and Adolescents: A Review of Coping Strategies and Parental Behaviors. *Current Psychiatry Reports, 14*(2), 87-95. doi: 10.1007/s11920-012-0254-2

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal Of Clinical Psychology, 65*(5), 467-487. doi: 10.1002/jclp.20593

- Slee, N., Garnefski, N., Spinhoven, P., & Arensman, E. (2008). The influence of cognitive emotion regulation strategies and depression severity on deliberate self-harm. *Suicide and Life-Threatening Behavior*, 38(3), 274–286. doi: 10.1521/suli.2008.38.3.274
- Sloper, P. & Lightfoot, J. (2003). Involving Disabled and Chronically Ill Children and Young People in Health Service Development. *Child Care, Health and Development*, 29(1), 15–20. doi: 10.1046/j.1365-2214.2003.00315.x
- Smith, J. K. (1983). Quantitative versus qualitative research: An attempt to clarify the issue. *Educational Researcher*, 12(3), 6–13.  
doi: 10.3102/0013189X012003006
- Smith, J. (1995) ‘Semi-structured interviewing and qualitative analysis’, in *Rethinking Methods in Psychology*, eds J. Smith, R. Harre & L. Van Langehove, Sage, London, pp. 9–26.
- Smith, J.A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11(2), 261–271. doi: 10.1080/08870449608400256
- Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology* 1(1), 39–54. doi: 10.1191/1478088704qp004oa

- Smith, J.A. & Eatough V. (2007). Interpretive Phenomenological Analysis. In E Lyons & A Coyle (eds) *Analysing qualitative data in psychology*. Sage pp35-50.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, Method, Research*. London: Sage.
- Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.), *Material discourses of health and mental illness*. London: Routledge.
- Smith, J.A., Harré, R., and Van Langenhove, L. (1995). Idiography and the case study. In Smith, J. A., Harre, R., and Van Langenhove, L., editors, *Rethinking psychology*. London: Sage.
- Smith, M., Hubbard, J., Laurenceau, J. P. (2011). Profiles of anger control in second-grade children: examination of self-report, observation, and physiological component. *Journal of Experimental Child Psychology*, 110(2), 213–226. doi: 10.1016/j.jecp.2011.02.006
- Smith, J.A., Jarman, M., & Osborne, M. (1999). Doing interpretative phenomenological analysis. In Murray, M. and Chamberlain, K., editors, *Qualitative health psychology: Theories and methods*. London: Sage.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In: J. A. Smith (Ed.), *Qualitative psychology: a practical guide to research methods*. London: Sage.

- Smith, J.A. & Osborn, M. (2008) [2nd edition]. Interpretative phenomenological analysis. In Smith, J. A., editor, *Qualitative psychology: A practical guide to methods*. London: Sage.
- Smyth, J. M. & Arigo, D. (2009). Recent evidence supports emotion-regulation interventions for improving health in at-risk and clinical populations. *Current Opinions in Psychiatry*, 22, 205–210. doi: 10.1097/YCO.0b013e3283252d6d
- Sohl, S. J., Moyer, A. (2009). Refining the Conceptualization of an Important Future-Oriented Self-Regulatory Behavior: Proactive Coping. *Pers Individ Dif* 47, (2), 139-144. doi: 10.1016/j.paid.2009.02.013
- Southam-Gerow, M. A., & Kendall, P. C. (2000). A preliminary study of the emotional understanding of youth referred for treatment of anxiety disorders. *Journal of Clinical Child Psychology*, 29(3), 319-327. doi: 10.1207/S15374424JCCP2903\_3
- Southam-Gerow, M. A., & Kendall, P. C. (2002). Emotion regulation and understanding: implications for child psychopathology and therapy. *Clinical psychology review*, 22(2), 189-222. doi:10.1016/S0272-7358(01)00087-3
- Sparrevohn R.M., Rapee R.M. (2009). Self-disclosure, emotional expression and intimacy within romantic relationships of people with social phobia. *Behavioural Research Therapy* 47(12), 1074–1078. doi:10.1016/j.brat.2009.07.016

- Spence, S. H. (1994). Preventive strategies. In T. H. Ollendick, N. J. King, & W. Yule(Eds.), *International handbook of phobic and anxiety disorders in children and adolescents* (pp. 453–474). New York: Plenum.
- Spence, S. H. (1996). The prevention of anxiety disorders in childhood. In P. Cotton, & H. Jackson (Eds.), *Early intervention & prevention in mental health* (pp. 87–107). Melbourne: The Australian Psychological Society.
- Spence, S. H. (1997). The structure of anxiety symptoms among children: A confirmatory factor analytic study. *Journal of Abnormal Psychology*, 106(2), 280-297. doi:10.1037/0021-843X.106.2.280
- Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour Research and Therapy*, 36(5), 545–566. doi:10.1016/S0005-7967(98)00034-5
- Spence, S. H., Barrett, P. M., & Turner, C. M. (2003). Psychometric properties of the Spence Children's Anxiety Scale with young adolescents. *Journal of Anxiety Disorders*, 17(6), 605–625. doi:10.1016/S0887-6185(02)00236-0
- Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (1999). Social skills, social outcomes, and cognitive features of childhood social phobia. *Journal of Abnormal Psychology*, 108(2), 211-221. doi:10.1037/0021-843X.108.2.211
- Spence, S.H., Donovan C, Brechman-Toussaint M. (2000). The Treatment of Childhood Social Phobia: The Effectiveness of a Social Skills Training-based, Cognitive-behavioural Intervention, with and without Parental

Involvement. *Journal of Child Psychology*, 41(6), 713–726.

doi: 10.1111/1469-7610.00659

Spence, S. H., & Shortt, A. L. (2007). Research review: Can we justify the widespread dissemination of universal, school-based interventions for the prevention of depression among children and adolescents? *Journal of Child Psychology and Psychiatry*, 48(6), 526–542. doi: 10.1111/j.1469-7610.2007.01738.x

Spinard, T. L., Eisenberg, N., Cumberland, A., Fabes, R. A., Valiente, C., Shepard, S. A., Reiser, M., Losoya, S., & Guthrie, I. K. (2006). Relation of emotion-related regulation to children's social competence: A longitudinal study. *Emotion*, 6(3), 498–510. doi: 10.1037/1528-3542.6.3.498

Spokas, M., Luterek, J. A., & Heimberg, R. G. (2009). Social anxiety and emotional inhibition: The mediating role of beliefs. *Journal of Behavior Therapy and Experimental Psychiatry*, 40(2), 283–291. doi: 10.1016/j.jbtep.2008.12.004

Spurr, J. M., & Stopa, L. (2002). Self-focused attention in social phobia and social anxiety. *Clinical Psychology Review*, 22(7), 947–975.  
doi:10.1016/S0272-7358(02)00107-1

Stallard, P., Simpson, N., Anderson, S., Hibbert, S., & Osborn, C. (2007). The FRIENDS Emotional Health Programme: Initial findings from a school-based project. *Child and Adolescent Mental Health*, 12(1), 32–37.  
doi: 10.1111/j.1475-3588.2006.00421.x

- Stallard, P., Simpson, N., Anderson, S., & Goddard, M. (2008). The FRIENDS emotional health prevention programme. *European Child and Adolescent Psychiatry*, 17(5), 283–289. doi: 10.1007/s00787-007-0665-5
- Stangier, U., Schramm, E., Heidenreich, T., Berger, M., & Clark, D.M. (2011). Cognitive therapy vs interpersonal psychotherapy in social anxiety disorder. *Archives of General Psychiatry*, 68(7), 692-700.
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–80. doi: 10.1177/1049732307307031
- Starcevic, V. E., Ljuhomir, E., Kelin, K., & Markovic-Zigic, D. (1994). The structure of discrete social phobias. *European Journal of Psychiatry*, 8, 140-148.
- Staugaard, S.R. (2010). Threatening faces and social anxiety: a literature review. *Clinical Psychology Review*, 30, 669–90. doi:10.1016/j.cpr.2010.05.001
- Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T. & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: An introduction. *Health Education Quarterly*, 19(1),1–8.
- Stein M.B., Fuetsch M., Muller N., Hofler M., Lieb R., Wittchen H-U. (2001). Social anxiety disorder and the risk of depression. *Arch Gen Psychiatry*; 58(3), 251–256.
- Stein, M. B., Jang, K. L., & Livesley, W. J. (2002). Heritability of social anxiety-related concerns and personality characteristics: A twin study. *Journal of*



*Nervous and Mental Disease*, 190(4), 219–224. doi: 10.1097/00005053-200204000-00002

Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review*, 28(1), 78–106.  
doi:10.1016/j.dr.2007.08.002

Stemmler, G. (1997). Selective activation of traits: Boundary conditions for the activation of anger. *Personality and Individual Differences*, 22(2), 213–233. doi:10.1016/S0191-8869(96)00189-4

Stravynski, A. (2007). *Fearing others: The nature and treatment of social phobia*. Cambridge: Cambridge University Press.

Stemberger, R. T., Turner, S. M., Beidel, D. C., & Calhoun, K. S. (1995). Social phobia: An analysis of possible developmental factors. *Journal of Abnormal Psychology*, 104(3), 526–531. doi:10.1037/0021-843X.104.3.526

Stopa, L., & Clark, D. M. (1993). Cognitive processes in social phobia. *Behaviour Research and Therapy*, 31(3), 255–267. doi:10.1016/0005-7967(93)90024-O

Strahan, E. (1998). Social anxiety and its effects on performance and perception. *Journal of Anxiety Disorders*, 12(4), 293–305. doi:10.1016/S0887-6185(98)00016-4

Strahan, E. Y., & Conger, A. J. (1999). Social anxiety and social performance: why don't we see more catastrophes? *Journal of Anxiety Disorders*, 13(4), 399–416. doi:10.1016/S0887-6185(99)00006-7

- Strauman, T. J. (1989). Self-discrepancies in clinical depression and social phobia: Cognitive structures that underlie emotional disorders? *Journal of Abnormal Psychology*, 98(1), 14–22. doi:10.1037/0021-843X.98.1.14
- Strauss, C. C., & Last, C. G. (1993). Social and simple phobias in children. *Journal of Anxiety Disorders*, 7(2), 141-152. doi:10.1016/0887-6185(93)90012-A
- Strauss, C. C., Frame, C. L., & Forehand, R. (1987). Psychosocial impairment associated with anxiety in children. *Journal of Clinical Child Psychology*, 16(3), 235–239. doi: 10.1207/s15374424jccp1603\_
- Summerfeldt, L. J., Kloosterman, P. H., Antony, M. M., & McCabe, R. E., & Parker, J. D. A. (2011). Emotional intelligence in social phobia and other anxiety disorders. *Journal of Psychopathology and Behavioral Assessment*, 33, 69-78. doi 10.1007/s10862-010-9199-0
- Sung, S. C., Porter, E., Robinaugh, D. J., Marks, E. H., Marques, L. M., Otto, M. W., Simon, N. M. (2012). Mood regulation and quality of life in social anxiety disorder: an examination of generalized expectancies for negative mood regulation. *Journal of Anxiety Disorders*, 26(3), 435–441. doi:10.1016/j.janxdis.2012.01.004.
- Suveg, C., Kendall, P. C., Comer, J. S. & Robin, J. (2006). Emotion-focused cognitive- behavioral therapy for anxious youth: a multiple-baseline evaluation. *Journal of Contemporary Psychotherapy*, 36(2), 77–85. doi: 10.1007/s10879-006-9010-4

- Suveg, C., Sood, E., Comer, J. S. & Kendall, P. C. (2009). Changes in emotion regulation following cognitive-behavioral therapy for anxious youth. *Journal of Clinical Child and Adolescent Psychology*, 38(3), 390–401. DOI: doi: 10.1080/15374410902851721
- Suveg, C., Southam-Gerow, M. A., Goodman, K. L. & Kendall, P. C. (2007). The role of emotion theory and research in child therapy development. *Clinical Psychology- Science and Practice*, 14(4), 358–371. doi: 10.1111/j.1468-2850.2007.00096.x
- Suveg, C., & Zeman, J. (2004). Emotion regulation in children with anxiety disorders. *Journal of Clinical Child and Adolescent Psychology*, 33(4), 750–759. doi: 10.1207/s15374424jccp3304\_10
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using Multivariate Statistics (5th ed.)*. Boston, MA: Pearson and Allyn & Bacon.
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Applied Social Research Methods Series (Vol. 46). Thousand Oaks, CA: Sage.
- Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.
- Taylor, S. E. (1991). Asymmetrical effects of positive and negative events: The mobilization-minimization hypothesis. *Psychological Bulletin*, 110 (1), 67-85. doi:10.1037/0033-2909.110.1.67
- Teachman, B. A., & Allen, J. P. (2007). Development of social anxiety: Social interaction predictors of implicit and explicit fear of negative evaluation.

*Journal of Abnormal Child Psychology*, 35(1), 63-78. doi:  
10.1007/s10802-006-9084-1

Tenenbaum, H., Alfieri, L., Brooks, P., & Dunne, G. (2008). The effects of explanatory conversations on children's emotion understanding. *British Journal of Developmental Psychology*, 26(2), 249-263.  
doi: 10.1348/026151007X231057

Theodorakis, Y., Hatzigeorgiadis, A., & Chroni, S. (2008). Self-talk: it works, but how? Development and preliminary validation of the functions of self-talk questionnaire. *Measurement in Physical Education and Exercise Science*, 12(1), 10-30. doi: 10.1080/10913670701715158

Thienemann, M., Moore, P. & Tompkins, K. (2006). A parent-only group intervention for children with anxiety disorders: pilot study. *Journal of American Academy of Child and Adolescent Psychiatry*, 45(1), 37-46.  
doi:10.1097/01.chi.0000186404.90217.02

Thompson, R. A. (1991). Emotional regulation and emotional development. *Educational Psychology Review*, 3(4), 269-307. doi: 10.1007/BF01319934

Thompson, R. A. (1994). Emotion regulation: A theme in search of definition. *Monographs for the Society for Research in Child Development*, 59(2-3), 25-52. doi: 10.1111/j.1540-5834.1994.tb01276.x

Thompson, R. A., & Calkins, S. D. (1996). The double-edged sword: emotional regulation for children at risk. *Development and Psychopathology*, 8(1), 163-182. <http://dx.doi.org/10.1017/S0954579400007021>

- Thompson, A.R., Kent, G., and Smith, J.A. (2002). Living with vitiligo: dealing with difference. *British Journal of Health Psychology* 7(2), 213–225. doi: 10.1348/135910702169457
- Thompson, R.A., Lewis, M.D., & Calkins, S.D. (2008) Reassessing emotion regulation. *Child Development Perspectives*, 2(3), 124–131. doi: 10.1111/j.1750-8606.2008.00054.x
- Thompson, S., & Rapee, R. M. (2002). The effect of situational structure on the social performance of socially anxious and non-anxious participants. *Journal of Behavior Therapy and Experimental Psychiatry*, 33(2), 91–102. doi:10.1016/S0005-7916(02)00021-6
- Tice, D.M., & Bratslavsky, E. (2000). Giving in to Feel Good: The Place of Emotion Regulation in the Context of General Self–Control. *Psychological Inquiry*, 11 (3), 149–159. doi: 10.1207/S15327965PLI1103\_03
- Tillfors, M., El-Khoury, B., Stein, M. B., & Trost, K. (2009). Relationships between social anxiety, depressive symptoms, and antisocial behaviors: evidence from a prospective study of adolescent boys. *Journal of Anxiety Disorders*, 23(5), 718–24. doi: 10.1016/j.janxdis.2009.02.011
- Thornicroft, G., & Tansella, M. (1999). *The mental health matrix: A manual to improve services*. Cambridge, UK: University Press.
- Townsley, R. (1992). Social phobia: Identification of possible etiological factors. Unpublished doctoral dissertation, University of Georgia, Athens.

- Tracy, J. L., Klonsky, E. D., & Proudfit, G. H. (2014). How Affective Science Can Inform Clinical Science: An Introduction to the Special Series on Emotions and Psychopathology. *Clinical Psychological Science*, 2(4), 371–386. doi: 10.1177/2167702614537627
- Trentacosta, C. (2010). Emotion Knowledge, Social Competence, and Behaviour Problems in Childhood and Adolescence: A Meta-analytic Review. *Social Development*, 19(1), 1-29. doi: 10.1111/j.1467-9507.2009.00543.x
- Trentacosta, C., & Izard, C. (2007). Kindergarten children's emotion competence as a predictor of their academic competence in first grade. *Emotion*, 7(1), 77–88. <http://dx.doi.org/10.1037/1528-3542.7.1.77>
- Troy, A.S., Mauss, I.B. (2011). Resilience in the face of stress: Emotion regulation as a protective factor. In: Southwick, S.M., Litz, B.T., Charney, D., Friedman, M.J., eds. *Resilience and Mental Health: Challenges Across the Lifespan*. New York, NY: Cambridge University Press; 30–44.
- Troy, A. S., Wilhelm, F. H., Shallcross, A. J., & Mauss, I. B. (2010). Seeing the silver lining: Cognitive reappraisal ability moderates the relation between stress and depressive symptoms. *Emotion*, 10(6), 783–795. doi:10.1037/a0020262
- Turk, C. L., Heimberg, R. G., Luterek, J. A., Mennin, D. S., & Fresco, D. M. (2005). Emotion dysregulation in generalized anxiety disorder: A comparison with social anxiety disorder. *Cognitive Therapy and Research*, 29(1), 89-106. doi: 10.1007/s10608-005-1651-1

- Turk, C. L., Heimberg, R. G., & Magee, L. (2008). Social Anxiety Disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp.123-163). New York: Guildford Press.
- Turner, S. M., Beidel, D. C., & Cooley-Quille, M. R. (1997). Social effectiveness therapy: A program for overcoming social anxiety and social phobia. Toronto, Ontario, Canada: Multi-Health Systems.
- Turner S.M., Beidel D.C., Cooley M.R., Woody S.R., Messer S.C. (1994). A multicomponent behavioral treatment for social phobia: Social effectiveness therapy. *Behavioural Research Therapy* 32(4), 381–390. doi:10.1016/0005-7967(94)90001-9
- Turner, S. M., Johnson, M. R., Beidel, D. C., Heiser, N. A., & Lydiard, R. B. (2003). The Social Thoughts and Beliefs Scale: A new inventory for assessing cognitions in social phobia. *Psychological Assessment*, 15(3), 384–391. doi:10.1037/1040-3590.15.3.384
- Tuschen-Caffier, B., Köhl, S., & Bender, C. (2011). Cognitive-evaluative features of childhood social anxiety in a performance task. *Journal of behavior therapy and experimental psychiatry*, 42(2), 233-239. doi:10.1016/j.jbtep.2010.12.005
- Tuschen-Caffier B, Köhl S, Bender C. (2009). Soziale Ängste und Soziale Angststörung im Kindes- und Jugend-alter. *Ein Therapiemanual*. Göttingen, Hogrefe.

- Vasey, M. W., Crnic, K. A., & Carter, W. G. (1994). Worry in childhood: A developmental perspective. *Cognitive Research and Therapy* 18(6), 529-547. doi: 10.1007/BF02355667
- Vasey, M.W., & Dadds, M.R. (2001). An introduction to the developmental psychopathology of anxiety. In M.W. Vasey & M.R. Dadds (Eds.), *The developmental psychopathology of anxiety* (pp. 3–26). Oxford: Oxford University Press.
- Vassilopoulos, S. P., & Banerjee, R. (2011). Social Anxiety and Content Specificity of Interpretation and Judgemental Bias in Children. *Infant and Child Development*, 21(3), 298–309. doi: 10.1002/icd.746
- Vassilopoulos, S. P., Banerjee, R., & Prantzalou, C. (2009). Experimental modification of interpretation bias in socially anxious children: changes in interpretation, anticipated interpersonal anxiety, and social anxiety symptoms. *Behaviour Research and Therapy*, 47, 1085–1089. doi: 10.1016/j.brat.2009.07.018
- Verduin, T. L., & Kendall, P. C. (2008). Peer perceptions and liking of children with anxiety disorders. *Journal of Abnormal Child Psychology*, 36(4), 459-469. doi: 10.1007/s10802-007-9192-6
- Verhulst, F. C., van der Ende, J., Ferdinand, R. F., & Kasius, M. C. (1997). The prevalence of DSM-III-R diagnoses in a national sample of Dutch adolescents. *Archives of General Psychiatry*, 54(4), 32-336. doi:10.1001/archpsyc.1997.01830160049008.



- Viana, A. G., Rabian, B., & Beidel, D. C. (2008). Self-report measures in the study of comorbidity in children and adolescents with social phobia: Research and clinical utility. *Journal of Anxiety Disorders*, 22(5), 781–792. doi:10.1016/j.janxdis.2007.08.005
- Victor, A. M., Bernat, D. H., Bernstein, G. A. & Layne, A. E. (2007). Effects of parent and family characteristics on treatment outcome of anxious children. *Journal of Anxiety Disorders*, 21(6), 835–848. doi: 10.1016/j.janxdis.2006.11.005
- Volling, B. L., McElwain, N. L., & Miller, A. L. (2002). Emotion regulation in context: The jealousy complex between young siblings and its relations with child and family characteristics. *Child Development*, 73(2), 581–600. doi: 10.1111/1467-8624.00425
- Voncken, M. J., & Bögels, S. M. (2008). Social performance deficits in social anxiety disorder: reality during conversation and biased perception during speech. *Journal of Anxiety Disorders*, 22(8), 1384–1392. doi:10.1016/j.janxdis.2008.02.001
- Voncken, M. J., & Bögels, S. M. (2009). Physiological blushing in social anxiety disorder patients with and without blushing complaints: two subtypes? *Biological Psychology*, 81(2), 86–94. doi:10.1016/j.biopsycho.2009.02.004
- Vosk B. N., Forehand R., Figueroa R. (1983). Perception of emotions by accepted and rejected children. *Journal of Behavioural Assessment*; 5(2), 151–160. doi: 10.1007/BF01321447

- Wagner, R., Silove, D., Marnane, C., & Rouen, D. (2006). Delays in referral of patients with social phobia, panic disorder and generalized anxiety disorder attending a specialist anxiety clinic. *Journal of Anxiety Disorders*, 20(3), 363–371. doi: 10.1016/j.janxdis.2005.02.003
- Walkerdine, V. (1993) 'Beyond Developmentalism?', *Theory & Psychology*, 3,(4), 451–469. doi: 10.1177/0959354393034004
- Waters, A. M., Wharton, T. A., Zimmer-Gembeck, M. J. & Craske, M. G. (2008). Threat- based cognitive biases in anxious children: comparison with non-anxious children before and after cognitive behavioural treatment. *Behaviour Research and Therapy*, 46(3), 358–374. doi:10.1016/j.brat.2008.01.002
- Watkins, E. R., Scott, J., Wingrove, J., Rimes, K., Bathurst, N., Steiner, H., Kennell-Webb, S., Moulds, M., & Malliaris, Y. (2007). Rumination-focused cognitive behaviour therapy for residual depression: A case series. *Behaviour Research and Therapy*, 45(9), 2144-2154. doi:10.1016/j.brat.2006.09.018
- Watson, W. (1990). Types of pluralism. *The Monist*, 73(3), 350–367.
- Watson, D., Clark, L. A., & Carey, G. (1988). Positive and negative affect and their relation to anxiety and depressive disorders. *Journal of Abnormal Psychology*, 97(3), 346-353. doi:10.1037/0021-843X.97.3.346
- Webb, T.L., Miles, E., & Sheeran, P. (2012). Dealing with feeling: A meta-analysis of the effectiveness of strategies derived from the process model

of emotion regulation. *Psychological Bulletin*, 138(4), 775-808. doi: 10.1037/a0027600

Weeks, J. W., Heimberg, R. G., Fresco, D. M., Hart, T. A., Turk, C. L., Schneier, F. R., et al. (2005). Empirical validation and psychometric evaluation of the Brief Fear of Negative Evaluation Scale in patients with social anxiety disorder. *Psychological Assessment*, 17(2), 179-190. doi:10.1037/1040-3590.17.2.179

Weeks, J. W., Heimberg, R. G., & Rodebaugh, T. L. (2008). Exploring the relationship between fear of positive evaluation and social anxiety. *Journal of Anxiety Disorders*, 22(3), 386–400. doi:10.1016/j.janxdis.2007.04.009

Weems, C. F. (2008). Developmental trajectories of childhood anxiety: Identifying continuity and change in anxious emotion. *Developmental Review*, 28(4), 488–502. doi:10.1016/j.dr.2008.01.001

Weems, C. F., & Costa, N. M. (2005). Developmental differences in the expression of childhood anxiety symptoms and fears. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(7), 656–663. doi:10.1097/01.chi.0000162583.25829.4b

Weiller, E., Bissierbe, J. C., Boyer, P., Lepine, J. P. & Lecrubier, Y. (1996). Social Phobia in general health care: An unrecognised undertreated disabling disorder. *British Journal of Psychiatry* 168, 169-174. doi: 10.1192/bjp.168.2.169

Weist, M. D. (1999). Challenges and opportunities in expanded school mental health. *Clinical Psychology Review*, 19, 131–135.

- Weisz, J. R., Suwanlert, S., Chaiyasit, W., Weiss, B., Walter, B., & Anderson, W. (1988). Thai and American perspectives on over- and undercontrolled child behavior problems: exploring the threshold model among parents, teachers, and psychologists. *Journal of Consulting and Clinical Psychology, 56*(4), 601–609. doi:10.1037/0022-006X.56.4.601
- Wells, A., Clark, D. M., Salkovskis, P., Ludgate, J., Hackmann, A., & Gelder, M. (1995). Social phobia: the role of in-situation safety behaviors in maintaining anxiety and negative beliefs. *Behavior Therapy, 26*(1), 153–161. doi:10.1016/S0005-7894(05)80088-7
- Wells, A., & Papageorgiou, C. (1998). Social phobia: effects of external attention on anxiety, negative beliefs, and perspective taking. *Behavior Therapy, 29*(3), 357–370. doi:10.1016/S0005-7894(98)80037-3
- Werner, K. H., Goldin, P. R., Ball, T. M., Heimberg, R. G., & Gross, J. J. (2011). Assessing emotion regulation in social anxiety disorder: The Emotion Regulation Interview. *Journal of Psychopathology and Behavioral Assessment, 33*, 346–354. doi 10.1007/s10862-011-9225-x
- Werner, K. & Gross, J. J. (2010). Emotion Regulation and Psychopathology. In: A. M. Kring, & D. M. Sloan (Eds.), *Emotion regulation and psychopathology: a transdiagnostic approach to etiology and treatment* (pp. 13–37). New York: Guilford.
- Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counselling Psychology, 52*(2), 167–177. doi:10.1037/0022-0167.52.2.167

- Westenberg, P. M., Drewes, M. J., Goedhart, A. W., Siebelink, B. M., & Treffers, Ph. D. A. (2004). A developmental analysis of self reported fears in late childhood through mid adolescence: social-evaluative fears on the rise? *Journal of Child Psychology and Psychiatry*, 45(3), 481–495.  
doi: 10.1111/j.1469-7610.2004.00239.x
- Wiens, A. N., Harper, R. G., & Matarazzo, J. D. (1980). Personality correlates of nonverbal interview behavior. *Journal of Clinical Psychology*, 36(1), 205-215. [http://dx.doi.org/10.1002/1097-4679\(198001\)36:1<205::AID-JCLP2270360126>3.0.CO;2-A](http://dx.doi.org/10.1002/1097-4679(198001)36:1<205::AID-JCLP2270360126>3.0.CO;2-A)
- Wilding, C. & Milne, A. (2010). *Teach yourself cognitive behavioural therapy*. London, U.K: McGraw-Hill.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Wilson, S. J., & Lipsey, M. W. (2007). School-based interventions for aggressive and disruptive behavior: Update of a meta-analysis. *American Journal Preventive Medicine*, 33(2 Suppl), S130–S143.  
doi: 10.1016/j.amepre.2007.04.011
- Wilson, J. K., & Rapee, R. M. (2005). The interpretation of negative social events in social phobia: Changes during treatment and the relationship to outcome. *Behaviour Research and Therapy*, 43(3), 373–389.  
doi:10.1016/j.brat.2004.02.006

- Wilson, J. K., & Rapee, R. M. (2006). Self-concept certainty in social phobia. *Behaviour Research and Therapy*, 44(1), 113–136.  
doi:10.1016/j.brat.2005.01.006
- Winton, E. C., Clark, D. M., & Edelmann, R. J. (1995). Social anxiety, fear of negative evaluation and the detection of negative emotion in others. *Behaviour Research and Therapy*, 33(2), 193– 196. doi:10.1016/0005-7967(94)E0019-F
- Wittchen, H. U., & Fehm, L. (2003). Epidemiology and natural course of social fears and social phobia. *Acta Psychiatrica Scandinavica, Supplementum* 108 (417), 4-18. doi: 10.1034/j.1600-0447.108.s417.1.x
- Wittchen, H.U., Fuetsch, M., Sonntag, H., Müller, N., Liebowitz, M. (2000). Disability and quality of life in pure and comorbid social phobia - Findings from a controlled study. *European Psychiatry*, 15(1), 46-58.  
doi:10.1016/S0924-9338(00)00211-X
- Wittchen, H. U., Stein, M. B., & Kessler, R. C. (1999). Social fears and social phobia in a community sample of adolescents and young adults: prevalence, risk factors and co-morbidity. *Psychological Medicine* 29: 309-323. doi: 10.1017/S0033291798008174
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Wood, J. (2006). Effect of anxiety reduction on children's school performance and social adjustment. *Developmental Psychology*, 42(2), 345–349. doi: 10.1037/0012-1649.42.2.345

- Wood, J., McLeod, B. D., Sigman, M., Hwang, W. C., & Chu, B. C. (2003). Parenting and childhood anxiety: Theory, empirical findings, and future directions. *Journal of Child Psychology and Psychiatry*, 44(1), 134–151. doi: 10.1111/1469-7610.00106
- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(3), 314–321. doi:10.1097/01.chi.0000196425.88341.b0
- Woodhouse, B. (2004). Re-Visioning Rights for Children', in P. Pufall and R. Unsworth (eds) *Rethinking Childhood*, pp. 229–43. New Jersey: Rutgers University Press.
- Woody, S. R., Chambless, D. L., & Glass, C. R. (1997). Self-focused attention in the treatment of social phobia. *Behaviour Research and Therapy*, 35(2), 117–129. doi:10.1016/S0005-7967(96)00084-8
- World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report*. Geneva, Switzerland: World Health Organization, Department of Mental Health and Substance Abuse.
- Yap, M. B. H., Allen, N. B., Sheeber, L. (2007). Using an emotion regulation framework to understand the role of temperament and family processes in risk for adolescent depressive disorders. *Clinical Child Family Psychology Review* 10(2), 180–196. doi: 10.1007/s10567-006-0014-0

- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health* 15(2), 215-218. doi: 10.1080/08870440008400302
- Yardley, L. & Bishop, F.L. (2007) 'Mixing Qualitative and Quantitative Methods', in C. Willig, and W. Stainton-Rogers (eds), *Handbook of Qualitative Research in Psychology*. London: Sage.
- Yeganeh, R., Beidel, D. C., Turner, S. M., Pina, A. A., & Silverman, W. K. (2003). Clinical distinctions between selective mutism and social phobia: An investigation of childhood psychopathology. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(1),1069–1075.  
doi:10.1097/01.CHI.00000070262.24125.23
- Zalewski, M., Lengua, L. J., Wilson, A. C., Trancik, A., Bazinet, A. (2011). Emotion regulation profiles, temperament, and adjustment problems in preadolescents. *Child Development*, 82(3), 951–966. doi: 10.1111/j.1467-8624.2011.01575.x
- Zeman, J., Cassano, M., Perry-Parrish, C., & Stegall, S. (2006). Emotion regulation in children and adolescents. *Journal of Developmental Behavioral Pediatrics*, 27(2), 155–168.  
<http://dx.doi.org/10.1097/00004703-200604000-00014>
- Zeman, J., & Garber, J. (1996). Display rules for anger, sadness, and pain: it depends on who is watching. *Child Development*, 67(3), 957–973.  
doi: 10.2307/1131873



- Zeman, J., Penza, S., Shipman, K., & Young, G. (1997). Preschoolers as functionalists: The impact of social context on emotion regulation. *Child Study Journal*, 27, 41–67.
- Zeman, J., & Shipman, K. (1997). Social-contextual influences on expectancies for managing anger and sadness: the transition from middle childhood to adolescence. *Developmental Psychology*, 33(6), 917-924. doi:10.1037/0012-1649.33.6.917
- Zeman, J., Shipman, K., & Suveg, C. (2002). Anger and sadness regulation: Predictions to internalizing and externalizing symptoms in children. *Journal of Clinical Child and Adolescent Psychology*, 31(3), 393–398. doi: 10.1207/S15374424JCCP3103\_11
- Zimbardo, P. G., & Radl, S. (1981). *The shy child*. New York: McGraw-Hill.
- Zins, J. E., & Elias, M. J. (2006). Social and emotional learning. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III: Development, prevention, and intervention* (pp. 1–13). Bethesda, MD: National Association of School Psychologists.
- Zinsser, N., Bunker, L., & Williams, J. M. (2006). Cognitive techniques for building confidence and enhancing performance. In J. M. Williams (Ed.), *Applied sport psychology: Personal growth to peak performance* (5th ed.). (pp. 346-378) New York, NY: McGraw-Hill Companies

# Appendices

### *Appendix I: Ethical Approval*

The research for this project was submitted for ethics consideration under the reference **PSYC 11/ 012** in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 13/06/2011. The minor amendments were accepted on 29/12/2012.



## **Letter of Invitation**

### **Research project:**

The role of emotion regulation and the impact of the Emotional Competency Skills Training (ECST)<sup>4</sup> on children's thoughts and emotional reactions to social situations

We invite you and your child to take part in a research study from the department of Psychology, University of Roehampton. First, we wish you to know that taking part in this research is entirely voluntary. You may choose not to take part, or you may withdraw from the study at any time. Before you decide to take part, please take as much time as you need to ask any questions.

### **Purpose and Procedures**

The aims of this study are to further our understanding of how children respond to social situations, and how it can affect their cognition, emotional state as well as their social skills.

At the beginning, your child and you will be given a few written questionnaires to complete. Please note that the questionnaires are designed simply to look at normal variation in aspects of emotion regulation and challenging situation, and not as tools to diagnose a mental illness.

The information acquired from you and your child will only be available to the research team who will treat this extremely confidential. Participation of the first study will involve one afternoon session, lasting about 40-60 minutes, whereby the second study will only last about 20 - 30 minutes and only your child will be required to take part. The third study (ECST, the training program) will last for the duration of 6 weeks in total. This will be divided in 45 minute afternoon sessions during normal school hours and within the school setting, whereby you as the parent will only be required to attend to 3 sessions divided over 6 weeks.

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<sup>4</sup> *The Emotional Competency Skills Training (ECST)* was renamed to *The Emotion and Social Skills Training for Children (ESST-C)* during the period of this research.

The cognitive and behavioural measures of study 2 involve a computer task (where attentional biases will be assessed, through the presentation of different stimuli)<sup>5</sup> as well as a 2 min speech task (which involves giving a speech in front of the researcher and a member of school staff while being video recording to ensure most accurate evaluation). Both experimental measures will be applied to examine the cognitive and behavioural reactions of your child to certain social situations.

During the ECST you and your child will be given different tasks to enhance emotional and attentional control. The efficacy of this training will be measured through similar questionnaires prior, post and in a follow-up after three months of completion of the ECST, in order to detect any improvements on your child's thoughts and emotional reactions to certain social situations. Additionally, the qualitative feedback of the teacher as well as the academic results will be taken into consideration to detect social, emotional and academic improvement. In the publication of this study, no individual results will be reported, purely an overall average to ensure the confidential treatment of your child's individual results.

### **Possible Side Effects and Hazards of the 2 min speech task**

This performance task is a widely used and scientifically proved measure used to assess levels of various components (e.g., Stress, Social anxiety). Nevertheless, it may expose your child to an uncomfortable situation, which is what we wish to find out in order to then focus on this unpleasantness in study 3 to improve the anxiety or discomfort experienced by your child in certain social situations such as this one. In any extreme cases, where the child's discomfort exceeds a certain level, the task will be terminated immediately. However, we would like you to know that this procedure is harmless and will not have any side effects due to the post treatment (training) and referral to counselling services if required, as provided on the debrief form. The video footage will be treated with highest confidentiality and only assessed by the panel.

### **Benefits**

Information learned from this study will be used to help our understanding of children's bodily and psychological reactions to social situations and may eventually lead to advances in the prevention and treatment of psychological discomforts. Furthermore, this study may help to discover new techniques for helping individuals to manage their stress and negative emotions.

---

<sup>5</sup> The computer task was not included due to limited resources within the schools.

Thank you for considering your contribution to this research project.

**Principal Investigator (signed)**

**Katere Pourseied**

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### **Letter of Invitation**

#### **Research project:**

The assessment of emotion regulation and social anxiety in children and young peoples' thoughts and emotional reactions to certain situations to examine the effects of the newly developed Emotional Competency Skills Training (ECST) for children.

We invite you and your child to take part in a research study from the department of Psychology, University of Roehampton. First, we wish you to know that taking part in this research is entirely voluntary. You may choose not to take part, or you may withdraw from the study at any time. Before you decide to take part, please take as much time as you need to ask any questions.

#### **Purpose and Procedures**

The aims of this study are to further our understanding of how children respond to social situations, and how it can affect their cognition, emotional state as well as their social skills.

At the beginning, your child and you will be given a few written questionnaires to complete. Please note that the questionnaires are designed simply to look at normal variation in aspects of emotion regulation and challenging situation, and not as tools to diagnose a mental illness. This is followed by a 3 month follow-up where you will be asked to complete further two questionnaires and your child the same questionnaires as three months ago, in order to detect any changes in your child due to their natural development.

The information acquired from you and your child will only be available to the research team who will treat this extremely confidential. Participation of this, as well as the follow-up study will involve 30 minutes for your child and not more than 10 minutes for you at both times.

In the publication of this study, no individual results will be reported, purely an overall average to ensure the confidential treatment of your child's individual results.

## **Possible Side Effects and Hazards**

There are not any known side effects or hazards in participating in this study, as it is purely questionnaire based and the assessment measures applied have all been validated for your child's as well as your age group in previous studies. Furthermore we will be providing you with contact details of the research team and counselling services if required, on the debrief form.

## **Benefits**

Information learned from this study will be used to help our understanding of children's reactions to social situations and may eventually lead to advances in the development of prevention and treatment of psychological discomforts. Furthermore, this study may help to discover new techniques for helping individuals to manage their stress and negative emotions.

Thank you for considering your contribution to this research project.

## **Principal Investigator (signed)**

### **Katere Pourseied**

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**ETHICS BOARD**

**PARTICIPANT CONSENT FORM**

**(PARENT/ GUARDIAN CONSENT FOR THEIR CHILD'S PARTICIPATION)**

**Title of Research Project:**

The role of emotion regulation and social anxiety in children's thoughts and emotional reactions to certain situations

**Brief Description of Research Project:**

This large study seeks to: to examine the association between emotion regulation (ER), cognitive factors, and social anxiety (SA) experimentally.

For this purpose, your child will be asked to complete a 2-min speech task, whereby he/she is exposed to a member of staff or researcher as well as a video camera to ensure the most accurate observation of your child's facial expression, conversation flow and discomfort felt during the speech. Subsequently, your child will be asked to complete a computer based test to assess their attentional bias. This research will be conducted within schools and their classrooms under the supervision of the investigator, teacher and other members of staff.

Please note that the tasks used in this study are not aimed at clinical evaluation. The data acquired will be treated anonymously, which means that your child's name will not be requested. However, in the case that your child wishes to participate in the third study and you agree, we will require contact details and a unique identification number you will be asked to create and note on your and the researchers consent form, which will both be treated with strictest confidentiality by the research team and used for the purpose of re-invitation only. The school may want to use some of the data merely for statistical purposes, in which case a summary of findings only, will be provided to them.

All observational and computer data will also be kept confidential and only be used for research purposes. Moreover, the video footage will be available to the panel only, which will treat their assessment and the identity of your child confidential.

You and your child have the right to withdraw from the study at any time. Should you or your child wish to withdraw the ID number provided on the consent form needs to be quoted so that the researchers will be able to identify his/her data.

**Investigator Contact Details:**

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Telephone: 020 8392 8140

**Consent Statement:**

- I agree for my child to take part in this study.
- I am also aware that my child can withdraw from this study at any time without needing to justify his/her decision.
- I understand that my child's entire personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).
- I agree to provide contact details purely for the purpose of re-invitation to the next study.
- I understand that the information which my child provides will be treated in confidence by the researcher and that my child's identity will be protected in the publication of any findings.

YES ..... NO .....

I agree that the data will be stored in a secure location for at least 6 years.

YES ..... NO .....

Child's name .....

Relationship to the child (i.e., parent, guardian or other)  
.....

Name .....

Contact details .....

.....

.....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your/your child's participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Director of this Study or the Head of Psychology.

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**(PARENT/ GUARDIAN CONSENT FOR THEIR CHILD'S PARTICIPATION)**

**Title of Research Project:**

The assessment of emotion regulation and social anxiety in children and young peoples' thoughts and emotional reactions to certain situations to examine the effects of the newly developed Emotional Competency Skills Training (ECST) for children.

**Brief Description of Research Project:**

This large study seeks to: (1) to assess the levels of emotion regulation (ER) and social anxiety (SA) in your child and to examine the association between levels of ER, and SA.

For this purpose, your child will be asked to complete a set of questionnaires, which will take a maximum of 60 minutes to complete. This research will be conducted within schools and their classrooms under the supervision of the investigator, teacher and possibly other members of staff (e.g., teacher assistant).

Please note that the questionnaires used in this study are not aimed at clinical evaluation. The questionnaires will be treated with strictest confidentiality by the research team and solely be used for research purposes. Your child's name and your contact details will be requested for the purpose of re-invitation only, as we will ask you to complete further questionnaires in three months' time. All questionnaires will be kept confidential and in case of any publications the overall data will be available without the identification of any individual or individual scores.

Your child as well as yourself have the right to withdraw from the study at any time. Should you or your child wish to withdraw you/he/she need(s) to quote the ID number provided on the consent form so that the researchers will be able to identify your/his/her data.

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Telephone: 020 8392 8140

**Consent Statement:**

- I agree for my child to take part in this study.
- I am also aware that my child can withdraw from this study at any time without needing to justify his/her decision.
- I understand that my child's entire personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).
- I agree to provide contact details purely for the purpose of re-invitation to the next study.
- I understand that the information which my child provides will be treated in confidence by the researcher and that my child's identity will be protected in the publication of any findings.

YES .....

NO .....

I agree that the data will be stored in a secure location for at least 6 years.

YES .....

NO .....

Child's name .....

Relationship to the child (i.e., parent, guardian or other)  
.....

Name .....

Contact details .....

.....

.....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your/your child's participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Director of this Study or the Head of Psychology.

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**ETHICS BOARD**

**PARTICIPANT CONSENT FORM**

(PARENT/ GUARDIAN CONSENT FOR THEIR CHILD'S PARTICIPATION)

**Title of Research Project:**

The role of emotion regulation and the impact of the Emotional Competency Skills Training (ECST) on children's thoughts and emotional reactions to certain situations

**Brief Description of Research Project:**

This large study seeks to: to evaluate the effectiveness of the training programme focussing on emotion regulation (ER) in particular in the reduction of negative thoughts and emotional reactions to certain social situations and with that the enhancement of social, emotional and academic skills in children.

For this purpose, you and your child will be offered to take part in a prevention programme. The ECST is based on "FRIENDS" by Essau and Conradt (2003) in an adjusted version for the purpose of this project and will last for 6 weeks for your child. The training programme will focus on teaching young children to certain skills to help them cope better with worries and concerns, which may affect their daily life and relations with others. Parallel to the training programme for children and adolescents, you as the parent will have the opportunity to participate in 3 sessions designed for parents, in the 2nd, 4th, and 6th week, offering you a summary of your child's process and important advice to support the efficiency of this programme. The training is aimed to reduce the levels of psychological discomfort in children and young people, for those participants and their parents, who would like to undergo this training programme. Furthermore, you and your child will be required to complete various questionnaires prior and past the completion of the ECST in order to detect any changes.

A 3-month follow-up study will be conducted to assess the efficacy of the training programme. In order to do so children, as well as you as their parent will be required to complete various questionnaires, this will not last longer than 30 - 40 min to complete. This research will be conducted within schools and their classrooms under the supervision of the investigator, teacher and other members of staff.

Please note that the ECST is not aimed at clinical evaluation. The data acquired will be treated with strictest confidentiality by the research team and solely used for the purpose of affectivity assessment. Signed consent form will be kept separately from all other data. In order to conduct the 3 month follow-up study we would require your contact details and a unique identification number you will be asked to create and note on your and the researchers consent form, which will both be treated with strictest confidentiality by the research team and used for the purpose of re-invitation only. The school may want to use some of the data merely for statistical purposes, in which case a summary of findings only, will be provided to them.

You and your child have the right to withdraw from the study at any time. Should you or your child wish to withdraw the ID number provided on the consent form needs to be quoted so that the researchers will be able to identify his/her data.

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- I agree to provide contact details purely for the purpose of re-invitation to the next study.
- I understand that the information which my child provides will be treated in confidence by the researcher and that my child's identity will be protected in the publication of any findings.

YES ..... NO .....

I agree that the data will be stored in a secure location for at least 6 years.

YES ..... NO .....

Child's name .....

Relationship to the child (i.e., parent, guardian or other)  
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Name .....

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**ETHICS BOARD**

**PARTICIPANT debrief form**

**Title of Research Project:**

The assessment of emotion regulation and social anxiety in children and young peoples' thoughts and emotional reactions to certain situations to examine the effects of the newly developed Emotional Competency Skills Training (ECST) for children.

The aim of this study was to further our understanding on cognitive and behavioural reactions to Social Anxiety (SA), and to examine the efficacy of the training programme. We expect that levels of cognitive and behavioural responses as indicators of SA will be associated with the level of emotion regulation and as a result the training programme focussing on emotion and attentional control will present success in the reduction of SA levels. Subsequently, this training programme could be integrated into the classroom curriculum to enhance the social, emotional, and academic skills of children.

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Please note: if you have a concern about any aspect of your, or your child's participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department or the Director of Studies).

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**School Counsellor:**

(NOTE: Details were added according to the relevant school)



**ETHICS BOARD**

**PARTICIPANT debrief form**

**Title of Research Project:**

The assessment of emotion regulation and social anxiety in children and young peoples' thoughts and emotional reactions to certain situations to examine the effects of the newly developed Emotional Competency Skills Training (ECST) for children.

The aim of this study was to further our understanding on children's reactions to certain social situations and to examine their levels of Social Anxiety (SA) and Emotion Regulation (ER) in children who have participated in the ECST as opposed to children who have not. We expect that levels of personal responses as indicators of SA will be associated with the level of ER and as a result training programmes focussing on emotion and attentional control will present success in the reduction of SA levels. Significant findings could support the integration of successful training programmes to the PSHE curriculum to enhance the social, emotional, and academic skills of children.

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## ERICA

Below are a number of statements. Please read each statement and then highlight the answer that seems most true for you.

Do not spend too much time on any one item. Remember, this is not a test.

There are no right or wrong answers. We really want to know what you think.

**1. I am a happy person**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**2. When adults are friendly to me, I am friendly to them**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**3. I handle it well when things change or I have to try something new**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**4. When I get upset, I can get over it quickly**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**5. When things don't go my way I get upset easily**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**6. When other kids are friendly to me, I am friendly to them**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**7. I have angry outbursts**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**8. I enjoy seeing others hurt or upset**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**9. I can be disruptive at the wrong times**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**10. I get angry when adults tell me what I can and cannot do**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**11. I am a sad person**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**12. I have trouble waiting for something I want**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**13. I am quiet and shy, and I don't show my feelings**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**14. I do things without thinking about them first**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**15. I When others are upset, I become sad or concerned for them**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**16. I annoy others by not minding my own business**

Strongly Disagree      Disagree      Half and Half      Agree      Strongly Agree

**Thank you for your help!**

## **PANAS-C**

This scale consists of a number of words that describe different feelings and emotions. Read each item and then highlight the appropriate answer, underneath the word, which indicates how much you have felt this way during the past few weeks.

### **Interested**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Sad**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Frightened**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Alert**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Excited**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Ashamed**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Upset**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Happy**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Strong**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

### **Nervous**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Guilty**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Energetic**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Scared**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Calm**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Miserable**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Jittery**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Cheerful**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Active**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Proud**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Afraid**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Joyful**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Lonely**

Not much or no at all	A little	Some	Quite a bit	A lot
-----------------------	----------	------	-------------	-------

**Mad**

Not much or no at all      A little      Some      Quite a bit      A lot

**Fearless**

Not much or no at all      A little      Some      Quite a bit      A lot

**Disgusted**

Not much or no at all      A little      Some      Quite a bit      A lot

**Delighted**

Not much or no at all      A little      Some      Quite a bit      A lot

**Blue**

Not much or no at all      A little      Some      Quite a bit      A lot

**Daring**

Not much or no at all      A little      Some      Quite a bit      A lot

**Gloomy**

Not much or no at all      A little      Some      Quite a bit      A lot

**Lively**

Not much or no at all      A little      Some      Quite a bit      A lot

**Thank you for completing the questionnaire!**

## SPAI-C

**Your Name:**

**Your Age:**

Below are some places or activities that sometimes make boys or girls feel nervous or scared. All of these activities are called social situations because they involve being with other people.

Social situations include playing outside with other boys and girls, playing a sport while others are watching, being in a play or recital, going to a party or a meeting, playing at the playground, or just being around other boys and girls at school.

Think about yourself and shade the circle that shows how often you would feel nervous or scared when doing this.

- 1. I feel scared when I have to join in a social situation with a large group of boys and girls (more than 6)**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

- 2. I feel scared when I am with other boys and girls or adults and I become the centre of attention (they all look at me)**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

- 3. I feel scared when I am with other boys and girls or adults and I have to do something while they watch me (read aloud, play a game, play a sport)**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

- 4. I feel scared when I have to speak or read in front of a group of people**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

Please turn to the next page.

**5. I feel scared when answering questions in class or meetings (scouts, soccer team) even when I know the answer**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**6. I feel so scared at parties, dances, school, or any place where there will be more than two other people that I go home early**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**7. I feel scared when I meet new kids**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**8. I am too scared to ask questions in class**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**9. I feel scared when I am in the school cafeteria with**  
**a) boys or girls my age that I know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**c) boys or girls my age that I don't know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) adults**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**10. If somebody starts arguing with me, I feel scared and do not know what to do if that person is**

**a) a boy or girl my age who I know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

Please turn to the next page.



**b) a boy or girl my age who I don't know**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**c) an adult**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**11. If somebody asks me to do something that I don't want to do, I feel scared and don't know what to say if that person is**

**a) a boy or girl my age who I know**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**b) a boy or girl my age who I don't know**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**c) an adult**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**12. I feel scared and don't know what to do when in an embarrassing situation (Embarrassed means that your face gets hot and red) with**

**a) a boy or girl my age who I know**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**b) a boy or girl my age who I don't know**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

**c) an adult**

Never, or hardly ever  
☐

Sometimes  
☐

Most of the time, or always  
☐

Please turn to the next page.

**13. If somebody says something that I think is wrong or bad, I feel scared saying what I think if that person is**

**a) a boy or girl my age who I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) a boy or girl my age who I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**c) an adult**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**14. I feel scared when I start to talk to**

**a) boys or girls my age that I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**c) adults**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**15. I feel scared if I have to talk for longer than a few minutes with**

**a) boys or girls my age that I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**c) adults**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

Please turn to the next page.

**16. I feel scared when speaking (giving a book report, reading in front of the class) in front of**

**a) boys or girls my age that I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**c) adults**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**17. I feel scared when I am in a school play, choir, music or dance recital in front of**

**a) boys or girls my age that I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**c) adults**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**18. I feel scared when I am ignored or made fun of by**

**a) boys or girls my age that I know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

☐

Sometimes

☐

Most of the time, or always

☐

Please turn to the next page.

c) **adults**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**19. I try to avoid social situations (parties, school, playing with others) where there are**  
**a) boys or girls my age that I know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

c) **adults**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**20. I leave social situations (parties, school, playing with others) where there are**  
**a) boys or girls my age that I know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) boys or girls my age that I don't know**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

c) **adults**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**21. Before going to a party or going someplace with others, I think about what might go wrong. I think**

**a) will I make a mistake and look stupid?**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) what if nobody talks to me?**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

Please turn to the next page.

**c) what if somebody talks to me and I can't think of what to say?**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**d) what if they see how scared I am?**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**22. My voice leaves me or sounds funny when I am talking to others**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**23. I usually do not speak to anyone until they speak to me**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**24. When I am with other people I think scary thoughts. Sometimes I think**

**a) if I goof up, I will really feel bad.**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) what are they thinking of me?**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**c) whatever I say, I will sound stupid.**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**25. Before I go someplace (a party, school, soccer game, or anyplace where I will be with others)**

**a) I feel sweaty**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) I feel like I have to go to the bathroom**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**c) my heart beats fast**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

Please turn to the last page.

**d) I get a headache or stomach-ache**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**e) my stomach feels funny**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**26. When I am some place (a party, school, soccer game, or anyplace where I will be with others)**

**a) I feel sweaty**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**b) I shake**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**c) I feel like I have to go to the bathroom**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**d) my heart beats fast**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

**e) I have a headache or stomach-ache**

Never, or hardly ever

Sometimes

Most of the time, or always

☐☐☐

Thank you very much for completing this questionnaire!

*Appendix XII: The Spence Children Anxiety Scale (SCAS-C)*

**SCAS-C**

Please put highlight the number that shows how often each of these things happen to you. There are no right or wrong answers.

	<b>Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
1. I worry about things	0	1	2	3
2. I am scared of the dark	0	1	2	3
3. When I have a problem, I get a funny feeling in my stomach	0	1	2	3
4. I feel afraid.	0	1	2	3
5. I would feel afraid of being on my own at home.	0	1	2	3
6. I feel scared when I have to take a test	0	1	2	3
7. I feel afraid if I have to use public toilets or bathrooms	0	1	2	3
8. I worry about being away from my parents	0	1	2	3
9. I feel afraid that I will make a fool of myself in front of people	0	1	2	3
10. I worry that I will do badly at my school work	0	1	2	3
11. I worry that something awful will happen to someone in my family	0	1	2	3

	<b>Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
12. I suddenly feel as if I can't breathe when there is no reason for this	0	1	2	3
13. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	0	1	2	3
14. I feel scared if I have to sleep on my own	0	1	2	3
15. I have trouble going to school in the mornings because I feel nervous or afraid	0	1	2	3
16. I am scared of dogs	0	1	2	3
17. I can't seem to get bad or silly thoughts out of my head	0	1	2	3
18. When I have a problem, my heart beats really fast	0	1	2	3
19. I suddenly start to tremble or shake when there is no reason for this	0	1	2	3
20. I worry that something bad will happen to me	0	1	2	3
21. I am scared of going to the doctors or dentists	0	1	2	3
22. When I have a problem, I feel shaky	0	1	2	3
23. I am scared of being in high places or elevators	0	1	2	3
24. I have to think of special thoughts (like numbers or words) to stop bad things from happening	0	1	2	3



	<b>Never</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
25. I feel scared if I have to travel in the car, or on a Bus or a train	0	1	2	3
26. I worry what other people think of me	0	1	2	3
27. I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	0	1	2	3
28. All of a sudden I feel really scared for no reason at all	0	1	2	3
29. I am scared of insects or spiders	0	1	2	3
30. I suddenly become dizzy or faint when there is no reason for this	0	1	2	3
31. I feel afraid if I have to talk in front of my class	0	1	2	3
32. My heart suddenly starts to beat too quickly for no reason	0	1	2	3
33. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	0	1	2	3
34. I am afraid of being in small closed places, like tunnels or small rooms	0	1	2	3
35. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	0	1	2	3
36. I get bothered by bad or silly thoughts or pictures in my mind	0	1	2	3
37. I have to do some things in just the right way to stop bad things happening	0	1	2	3
38. I would feel scared if I had to stay away from home overnight	0	1	2	3

**Thank you for completing this questionnaire!**

## **SPENCE CHILDREN'S ANXIETY SCALE (Parent Report)**

**Your Name:**

**Your Child's Name:**

**Your Child's School:**

BELOW IS A LIST OF ITEMS THAT DESCRIBE CHILDREN. FOR EACH ITEM PLEASE HIGHLIGHT THE RESPONSE THAT BEST DESCRIBES YOUR CHILD. PLEASE ANSWER ALL THE ITEMS.

**1. My child worries about things**

Never      Always      Sometimes      Often

**2. My child is scared of the dark**

Never      Always      Sometimes      Often

**3. When my child has a problem, s(he) complains of having a funny feeling in his / her stomach**

Never      Always      Sometimes      Often

**4. My child complains of feeling afraid**

Never      Always      Sometimes      Often

**5. My child would feel afraid of being on his/her own at home**

Never      Always      Sometimes      Often

**6. My child is scared when s(he) has to take a test**

Never      Always      Sometimes      Often

**7. My child is afraid when (s)he has to use public toilets or bathrooms**

Never      Always      Sometimes      Often

**8. My child worries about being away from us / me**

Never      Always      Sometimes      Often

**9. My child feels afraid that (s)he will make a fool of him/herself in front of people**

Never      Always      Sometimes      Often

**10. My child worries that (s)he will do badly at school**

Never      Always      Sometimes      Often

**11. My child worries that something awful will happen to someone in our family**

Never      Always      Sometimes      Often

**12. My child complains of suddenly feeling as if (s)he can't breathe when there is no reason for this**

Never      Always      Sometimes      Often

**13. My child has to keep checking that (s)he has done things right (like the switch is off, or the door is locked)**

Never      Always      Sometimes      Often

**14. My child is scared if (s)he has to sleep on his/her own**

Never      Always      Sometimes      Often

**15. My child has trouble going to school in the mornings because (s)he feels nervous or afraid**

Never      Always      Sometimes      Often

**16. My child is scared of dogs**

Never      Always      Sometimes      Often

**17. My child can't seem to get bad or silly thoughts out of his / her head**

Never      Always      Sometimes      Often

**18. When my child has a problem, s(he) complains of his/her heart beating really fast**

Never      Always      Sometimes      Often

**19. My child suddenly starts to tremble or shake when there is no reason for this**

Never      Always      Sometimes      Often

**20. My child worries that something bad will happen to him/her**

Never      Always      Sometimes      Often

**21. My child is scared of going to the doctor or dentist**

Never      Always      Sometimes      Often

**22. When my child has a problem, (s)he feels shaky**

Never      Always      Sometimes      Often

**23. My child is scared of heights (e.g. being at the top of a cliff)**

Never      Always      Sometimes      Often

**24. My child has to think special thoughts (like numbers or words) to stop bad things from happening**

Never      Always      Sometimes      Often

**25. My child feels scared if (s)he has to travel in the car, or on a bus or train**

Never      Always      Sometimes      Often

**26. My child worries what other people think of him/her**

Never      Always      Sometimes      Often

**27. My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)**

Never      Always      Sometimes      Often

**28. All of a sudden my child feels really scared for no reason at all**

Never      Always      Sometimes      Often

**29. My child is scared of insects or spiders**

Never      Always      Sometimes      Often

**30. My child complains of suddenly becoming dizzy or faint when there is no reason for this**

Never      Always      Sometimes      Often

**31. My child feels afraid when (s)he has to talk in front of the class**

Never      Always      Sometimes      Often

**32. My child's complains of his / her heart suddenly starting to beat too quickly for no reason**

Never      Always      Sometimes      Often

**33. My child worries that (s)he will suddenly get a scared feeling when there is nothing to be afraid of**

Never      Always      Sometimes      Often

**34. My child is afraid of being in small closed places, like tunnels or small rooms**

Never      Always      Sometimes      Often

**35. My child has to do some things over and over again (like washing his / her hands, cleaning or putting things in a certain order)**

Never      Always      Sometimes      Often

**36. My child gets bothered by bad or silly thoughts or pictures in his/her head**

Never      Always      Sometimes      Often

**37. My child has to do certain things in just the right way to stop bad things from happening**

Never      Always      Sometimes      Often

**38. My child would feel scared if (s)he had to stay away from home overnight**

Never      Always      Sometimes      Often

**39. Is there anything else that your child is really afraid of?**

YES NO

**Please write down what it is, and fill out how often (s)he is afraid of this thing:**

---

---

Never      Sometimes      Often      Always

---

---

Never      Sometimes      Often      Always

**Thank you very much for completing this questionnaire!**

## Strengths and Difficulties

### Questionnaire (P)

For each item, please highlight *Not True*, *Somewhat True* or *Certainly True*. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour **over the last six months**.

*Gender of child:*      *Male/Female*

*Age of child:*

*Name of Child:*

**1. Considerate of other people's feelings.**

Not true

Somewhat true

Certainly true

**2. Restless, overactive, cannot stay still for long**

Not true

Somewhat true

Certainly true

**3. Often complaints of headaches, stomach-aches or sickness**

Not true

Somewhat true

Certainly true

**4. Shares readily with other children (treats, toys, pencils, etc.)**

Not true

Somewhat true

Certainly true

**5. Often has temper tantrums or hot tempers**

Not true

Somewhat true

Certainly true



**6. Rather solitary, tends to play alone**

Not true                      Somewhat true                      Certainly true

**7. Generally obedient, usually does what adults request**

Not true                      Somewhat true                      Certainly true

**8. Many worries, often seems worried**

Not true                      Somewhat true                      Certainly true

**9. Helpful if someone is hurt, upset or feeling ill**

Not true                      Somewhat true                      Certainly true

**10. Constantly fidgeting or squirming**

Not true                      Somewhat true                      Certainly true

**11. Has at least one good friend**

Not true                      Somewhat true                      Certainly true

**12. Often fights with other children or bullies them**

Not true                      Somewhat true                      Certainly true

**13. Often unhappy, down-hearted or tearful**

Not true                      Somewhat true                      Certainly true

**14. Generally liked by other children**

Not true                      Somewhat true                      Certainly true

**15. Easily distracted, concentration wanders**

Not true                      Somewhat true                      Certainly true

**16. Nervous or clingy in new situations, easily loses confidence**

Not true                      Somewhat true                      Certainly true

**17. Kind to younger children**

Not true                      Somewhat true                      Certainly true

**18. Often lies or cheats**

Not true                      Somewhat true                      Certainly true

**19. Picked on or bullied by other children**

Not true                      Somewhat true                      Certainly true

**20. Often volunteers to help others (parents, teachers, children)**

Not true                      Somewhat true                      Certainly true

**21. Thinks things through before acting**

Not true                      Somewhat true                      Certainly true

**22. Steals from home, school, elsewhere**

Not true                      Somewhat true                      Certainly true

**23. Gets on better with adults than with other children**

Not true                      Somewhat true                      Certainly true

**24. Many fears, easily scared**

Not true                      Somewhat true                      Certainly true

**25. Sees tasks through to the end, good attention span**

Not true                      Somewhat true                      Certainly true

**Do you have any other comments or concerns?**

**Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?**

No      Yes-minor difficulties      Yes-definite difficulties      Yes-severe difficulties

**If you have answered "Yes", please answer the following questions about these difficulties:**

**How long have these difficulties been present?**

Less than one month      1-5 months      6-12 months      Over a year

**Do the difficulties upset or distress your child?**

Not at all      Only a little      Quite a lot      A great deal

Do the difficulties interfere with your child's everyday life in the following areas?

**Home Life?**

Not at all  
great deal

Only a little

Quite a lot

A

**Friendships?**

Not at all  
great deal

Only a little

Quite a lot

A

**Classroom Learning?**

Not at all  
great deal

Only a little

Quite a lot

A

**Leisure Activities?**

Not at all  
great deal

Only a little

Quite a lot

A

**Do the difficulties put a burden on you or the family as a whole?**

Not at all  
great deal

Only a little

Quite a lot

A

**Thank you very much for your help**

## Strengths and Difficulties Questionnaire (P) Follow-up

For each item, please highlight *Not True*, *Somewhat True* or *Certainly True*. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour **over the last month**.

*Gender of child:*      *Male/Female*                      *Age of child:*

*Name of Child:*

**1. Considerate of other people's feelings.**

Not true                      Somewhat true                      Certainly true

**2. Restless, overactive, cannot stay still for long**

Not true                      Somewhat true                      Certainly true

**3. Often complaints of headaches, stomach-aches or sickness**

Not true                      Somewhat true                      Certainly true

**4. Shares readily with other children (treats, toys, pencils, etc.)**

Not true                      Somewhat true                      Certainly true

**5. Often has temper tantrums or hot tempers**

Not true                      Somewhat true                      Certainly true

**6. Rather solitary, tends to play alone**

Not true                      Somewhat true                      Certainly true

**7. Generally obedient, usually does what adults request**

Not true                      Somewhat true                      Certainly true

**8. Many worries, often seems worried**

Not true                      Somewhat true                      Certainly true

**9. Helpful if someone is hurt, upset or feeling ill**

Not true                      Somewhat true                      Certainly true

**10. Constantly fidgeting or squirming**

Not true                      Somewhat true                      Certainly true

**11. Has at least one good friend**

Not true                      Somewhat true                      Certainly true

**12. Often fights with other children or bullies them**

Not true                      Somewhat true                      Certainly true

**13. Often unhappy, down-hearted or tearful**

Not true                      Somewhat true                      Certainly true

**14. Generally liked by other children**

Not true                      Somewhat true                      Certainly true

**15. Easily distracted, concentration wanders**

Not true                      Somewhat true                      Certainly true

**16. Nervous or clingy in new situations, easily loses confidence**

Not true                      Somewhat true                      Certainly true

**17. Kind to younger children**

Not true                      Somewhat true                      Certainly true

**18. Often lies or cheats**

Not true                      Somewhat true                      Certainly true

**19. Picked on or bullied by other children**

Not true                      Somewhat true                      Certainly true

**20. Often volunteers to help others (parents, teachers, children)**

Not true                      Somewhat true                      Certainly true

**21. Thinks things through before acting**

Not true                      Somewhat true                      Certainly true

**22. Steals from home, school, elsewhere**

Not true

Somewhat true

Certainly true

**23. Gets on better with adults than with other children**

Not true

Somewhat true

Certainly true

**24. Many fears, easily scared**

Not true

Somewhat true

Certainly true

**25. Sees tasks through to the end, good attention span**

Not true

Somewhat true

Certainly true

**Do you have any other comments or concerns?**

**Since coming to the training, are your child's problems:**

Much worse

A bit worse

About the same

A bit better

Much better



**Has attending this training been helpful in other ways, e.g., providing information or**

**making the problems more bearable:**

Not at all

Only a little

Quite a lot

A great deal

**Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?**

No

Yes-minor difficulties

Yes-definite difficulties

Yes-severe difficulties

**If you have answered "Yes", please answer the following questions about these difficulties:**

**Do the difficulties upset or distress your child?**

Not at all

Only a little

Quite a lot

A great deal

**Do the difficulties interfere with your child's everyday life in the following areas?**

**Home Life?**

Not at all

Only a little

Quite a lot

A great deal

**Friendships?**

Not at all

Only a little

Quite a lot

A great deal

**Classroom Learning?**

Not at all                      Only a little                      Quite a lot                      A great deal

**Leisure Activities?**

Not at all                      Only a little                      Quite a lot                      A great deal

**Do the difficulties put a burden on you or the family as a whole?**

Not at all                      Only a little                      Quite a lot                      A great deal

**Thank you very much for your help**

**The Speech Performance Rating Scale**

Name of Child/Participant No: \_\_\_\_\_

Rater Name: \_\_\_\_\_

Date: \_\_\_\_\_

**2 MIN – SPEECH TASK**

***GAZE***

**1(not very much) 2 (a bit) 3(quite a lot) 4(very much)**

Participant avoids looking at the audience	1	2	3	4
--	---	---	---	---

Participant avoids looking at the camera®	1	2	3	4
---	---	---	---	---

Participants' focus shifts during pauses	1	2	3	4
--	---	---	---	---

Participant maintains good eye contact®	1	2	3	4
---	---	---	---	---

***VOCAL QUALITY***

**1(not very much) 2 (a bit) 3(quite a lot) 4(very much)**

Participant speaks quietly or mumbles	1	2	3	4
---------------------------------------	---	---	---	---

Participant speaks overly loud	1	2	3	4
--------------------------------	---	---	---	---

Participant sounds enthusiastic ®                      1            2            3            4

Participant has a clear voice ®                      1            2            3            4

Participant stumbles over words                      1            2            3            4

***Content of talk***

**1(not very much) 2 (a bit) 3(quite a lot) 4(very much)**

Participant requires help (questions prompted by the panel)

1            2            3            4

Participant seems content and creative ®

1            2            3            4

Participant makes short statements with long pauses

1            2            3            4

Participant' s talk is continuous and makes sense ®

1            2            3            4

Participant's talk is incoherent

1            2            3            4

***Body Language/Facial Expression***

**1(not very much) 2 (a bit) 3(quite a lot) 4(very much)**

Participants body gesture is rigid

1            2            3            4

Participant continuously moves arms and/or legs

1            2            3            4

Participant blushes

1            2            3            4

Participants face and body posture look at ease ®

1            2            3            4

Participant smiles ®

1            2            3            4

Participant looks nervous

1            2            3            4

Participant refused to stand up for the talk

1            2            3            4

*Appendix XVII: ECST-C Evaluation Scale for Children*

ECST Evaluation for Youth

The questions below ask you about the ECST group that you have been doing. We are interested in finding out how much you enjoyed the programme, and how helpful it was for you. Your answers to these questions will help us improve the programme.

Please circle the answer that best describes the way you feel. Remember, there are no right or wrong answers, so please be as honest as you can.

**Name :** \_\_\_\_\_

**School:** \_\_\_\_\_

**Year :** \_\_\_\_\_



**1. How much did you enjoy the ECST Programme?**

1	2	3	4
A lot	Somewhat	A little	Not at all

**2. How much did you learn by doing the ECST-Programme with other children?**

1	2	3	4
A lot	Somewhat	A little	Not at all

**3. How much did you learn about feelings?**

1	2	3	4
A lot	Some	A little	Not at all

**4. How much did you learn about how to cope with feeling worried or upset?**

1	2	3	4
A lot	Some	A little	Not at all

**5. How often do you use the ideas (skills) that you learned in the ECST-Programme?**

1	2	3	4
All the time	Some of the time	Not very often	Not at all

**6. Which skills from the ECST Programme did you find most useful?**

Please tick.

- ☐ Relaxation exercises
- ☐ Deep breathing
- ☐ Thinking helpful thoughts
- ☐ Changing negative to positive thoughts
- ☐ Changing negative to positive emotions
- ☐ Step plan (breaking your fears into small steps)
- ☐ Problem solving plan
- ☐ Recognise feelings in yourself
- ☐ Recognise feelings in others
- ☐ Helping others to feel good

**7. Your comments help us to improve the programme. Do you have any other comments about the ECST-Programme you would like us to know?**

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Thank you very much!!!



*Appendix XVIII: ECST-C Evaluation Scale for Parents*

**Parents-Evaluations: ECST-Programme**

In order to continuously rate and improve on our programme, we would very much appreciate your comments and feedback.

The following questions are to assess your ratings concerning the ECST Programme. Please tick the most suitable answer to you. Furthermore, we are interested in any other comments and feedback which may help to improve the programme.

Please circle the answers to the questions that best describes the way you feel or you think your child feels.

**Name of your Child:** \_\_\_\_\_

**School of your Child:** \_\_\_\_\_

**Year of your Child:** \_\_\_\_\_

**Did you attend any parents' session?**

☐ Yes

☐ No

**How many sessions for parents did you attend to in total?** \_\_\_\_\_

**1. How useful do you think positive coping-skills programmes are in general?**

1	2	3	4
Very useful	Somewhat useful	A little useful	Not at all useful

**2. How useful, did you find the ECST-Programme for enhancing your child's coping skills?**

1	2	3	4
Very useful	Somewhat useful	A little useful	Not at all useful

**3. How important do you think it is that your child's school incorporate a programme like this into the curriculum?**

1	2	3	4
Very useful	Somewhat useful	A little useful	Not at all useful

**4. How much did you learn about enhancing your child's coping skills?**

1	2	3	4
Very useful	Somewhat useful	A little useful	Not at all useful

**5. How much do you think did your child learned about understanding feelings in themselves and others?**

1	2	3	4
A lot	Some	A little	Nothing at all

**6. How much do you think your child learned about coping with these feelings?**

1	2	3	4
A lot	Some	A little	Nothing at all

**7. How much do you think your child enjoyed the ECST-Programme?**

1	2	3	4
A lot	Some	A little	Not at all

**8. How often do you use the ideas (skills) that you learned in the ECST-Parent sessions?**

1	2	3	4
All the time	Some of the time	Not very often	Not at all

**9. How often does your child use the ideas (skills) that they learned in the ECST-Programme?**

1	2	3	4
All the time	Some of the time	Not very often	Not at all

**10. Which skills from the ECST-Programme does your child find most useful? Please tick.**

- ☐ Relaxation exercises
- ☐ Deep breathing
- ☐ Thinking helpful thoughts
- ☐ Changing negative to positive thoughts
- ☐ Changing negative to positive emotions
- ☐ Step plan (breaking fears into small steps)
- ☐ Problem solving plan
- ☐ Recognise feelings in yourself
- ☐ Recognise feelings in others
- ☐ Helping others to feel good

**11. Please provide any other feedback (positive or negative) that you have:**

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Thank you very much!!!



## **Letter of Invitation**

### **Research project:**

The assessment of thoughts and reactions to certain social situations in children and their parents, to consider possible links between parents' and children's self-perception as well as the relationship between emotion regulation and anxiety levels.

We invite you and your child to take part in a research study from the department of Psychology, University of Roehampton. First, we wish you to know that taking part in this research is entirely voluntary. You may choose not to take part, or you may withdraw from the study at any time. Before you decide to take part, please take as much time as you need to ask any questions.

### **Purpose and Procedures**

The aims of this study are to further our understanding of how children respond to social situations, and how it can affect their cognition, emotional state as well as their social skills as well as how these reactions are linked with their parents' levels of emotion regulation and anxiety, through qualitative research methods.

The procedure consists of a 30-40min interview with you and your child individually (usually 20min (maximum of 30)) with children and 40min (maximum of 60 with parents). Following your interview there will be two questionnaires to complete regarding your general reactions to certain situations. Before participating, you will receive further information and a consent form. You will also be able to ask any questions you may have.

The information acquired from you and your child will only be available to the research team (which consists of the director of study, co-supervisor and main investigator) who will treat this with highest anonymity.

In the publication of this study, no individual results will be reported, purely an overall outcome to ensure the anonymous treatment of yours and your child's individual results.

### **Possible Side Effects and Hazards**

No discomfort or risks are expected from participating in this study. You may withdraw at any time and without giving a reason. All records will be kept in the utmost confidence. The questions asked have been approved by the Ethics committee of the University and are appropriate for the age groups involved. Furthermore we will be providing you with contact details of the research team and school SENCO services if required, on the debrief form.

### **Storage of Data:**

All identifying data will be stored in locked cabinets under the control of the research team. Raw and processed data (e.g., with codes) will be kept separately and held securely in password protected computer files and locked cabinets. No one outside of the research team will have access to your individual data, and anonymity will be protected at all times. Researchers involved in the study (except the main investigator and interviewer) will be unaware of any links between your identity and the data collected. Signed consent forms will be kept separately from all other data. Your identity will not be passed on to anyone who is not involved in this study, and will be protected in the publication of any findings. The University of Roehampton requires that all records be kept for a minimum of ten years following the last publication.

### **Benefits**

Information learned from this study will be used to further our understanding of children's reactions to social situations and what influences these. These findings may eventually lead to advances in the development of prevention and treatment of psychological discomforts and increase social and emotional awareness in both children and parents. Furthermore, this study may help to discover new techniques for helping individuals to manage their stress and negative emotions.

Thank you for considering your contribution to this research project.

December, 2012

*Katere Pourseied*

**Principal Investigator (signed)**

**Katere Pourseied**

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**ETHICS BOARD**

**PARTICIPANT CONSENT FORM**

**(PARENT/ GUARDIAN CONSENT FOR THEIR CHILD'S PARTICIPATION)**

**Title of Research Project:**

The assessment of thoughts and reactions to certain social situations in children and their parents, to consider possible links between parents' and children's self-perception as well as the relationship between emotion regulation and anxiety levels.

**Brief Description of Research Project:**

This study seeks to discover your and your child's personal experience of socially and emotionally challenging situations in order to examine the association between parents' and children's self-perception as well as the relationship between Emotion Regulation, and Social Anxiety.

For this purpose, both you and your child will be asked a number of questions individually, which will take a maximum of 40 minutes in total, depending on the extent of your and your child's responses. The questions are based on validated questionnaires for adults and children in this age group with the addition of asking children about your reactions to certain scenarios as well.<sup>6</sup>

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<sup>6</sup> The perceptions of parents' on their selves and children's perception of their parents were not included in the analysis of the current study due to space restrictions.



A few sample questions are provided below.

Questions for children:

- *Can you give me an example of a recent situation when you were very embarrassed?*
- *How would you describe your behaviour in that situation?*
- *Can you recall a recent situation where Mum/Dad seemed to be very embarrassed?*
- *How was Mummy/Daddy behaving in that situation?*

Questions for parents:

- *How would you describe your child's behaviour in a socially challenging situation?*
- *Could you give me an example of an emotionally challenging situation for your child and how (s)he dealt with it?*

This research will be conducted within school premises on a day and time agreed with you.

Please note that the interviews and questionnaires are not aimed at clinical evaluation. The responses will be treated with strictest anonymity by the research team and solely be used for research purposes. All transcripts, recordings and raw data will be kept anonymous and securely. In case of any publications only the overall data will be available without the identification of any individual information.

You and your child have the right to withdraw from the study at any time without needing to justify your decision.

**Main Investigator:**

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Telephone 020 8392 3080

**Consent Statement:**

- I agree to take part in this study.
- I agree for my child to take part in this study.
- I am also aware that we can withdraw from this study at any time without needing to justify our decision.
- I understand that the entire personal data acquired from my child and myself are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).
- I understand that the information that my child and myself provide will be treated in confidence and with strictest anonymity by the researcher and that our identities will be protected in the publication of any findings.

YES ..... NO .....

I agree that the transcripts and recordings will be stored in a secure location for at least 10 years.

YES ..... NO .....

Child's name .....

Relationship to the child (i.e., parent, guardian or other)

.....

Name .....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Director of this Study or the Head of Psychology.



**ETHICS BOARD**

**PARTICIPANT debrief form**

Thank you for participating in our study. We very much appreciate you taking the time to allow us to collect data for our research:

*The assessment of thoughts and reactions to certain social situations in children and their parents, to consider possible links between children's and parents' levels of emotion regulation and social anxiety.*

The aim of this study was to further our understanding on children's reactions to certain social situations and to examine both parents and children's levels of Social Anxiety (SA) and Emotion Regulation (ER). Furthermore we tried to find out the link between parents' and children's levels of ER and SA and possible regulation strategies. We expect that levels of personal responses, as indicators of SA, will be associated with the level of ER and as a result training programmes focussing on emotion and attentional control as well as the appropriate support for parents will present success in the reduction of SA levels and the increase of coping mechanisms in children. Furthermore, the knowledge of how socially and emotionally challenging situations is perceived by parents and their children will support the improvement of existing and possibly the development of new prevention programmes for children. This in turn can result in the integration of successful training programmes to the PSHE curriculum to enhance the social, emotional, and academic skills of children.

**Main Investigator:**

Katere Pourseied  
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Please note: if you have a concern about any aspect of your, or your child's participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department or the Director of Study.

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If you are troubled or worried about any aspect of the study, or issues it may have raised, you may find it helpful to contact the School's SENCO.

*Appendix XXII: Participant's Demographics Questionnaire*



Dear Participant,

Please answer the following questions

In this questionnaire, we ask a number of questions about your background. You are not obligated to answer any of them and may skip questions you do not feel comfortable answering.

1.	How old are you?
2.	What is your gender
3.	Please list your ethnicity (or ethnicities)
4.	What languages do you speak?
5.	What is your marital status?
6.	What is your occupation?

Questions about your child

1.	How old is your child?
2.	What is the gender of your child?
3.	Please list your child's ethnicity (or ethnicities)
4.	What languages does your child speak?
5.	How many siblings (including step-) does your child have?

6. What school year is your child in?
---------------------------------------

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the researcher. However if you would like to contact an independent party please contact the Head of Department.

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### **Semi-Structured Interview Schedule (C)**

#### **Title of Research Project:**

The assessment of thoughts and reactions to certain social situations in children and their parents

#### **Example Questions:**

##### **Questions on SA** (Child's self-perception on their SA levels)

1. *Can you give me an example of a recent situation when **you** were very embarrassed? (prompts: school, sport club, play day etc.)*
2. *Why do you think you felt that way?*
3. *What did you do in that situation?*
4. *Can you tell me about any other recent events where you felt uncomfortable because of other people around? Or situations in general where you feel uncomfortable because of other people around?*
5. *What do you find most difficult in those situations?*
6. *How did you behave? Why? What happened?*

##### **Questions on ER** (Child's self-perception on their ER levels)

1. *Can you give me an example of a recent situation when you were very upset or stressed out?*
2. *What did you do? (behaviour)*
3. *Can you tell me remember a time when you were very happy or excited?*
4. *What happened? What did you do? (behaviour)*
5. *What do you usually do when you are extremely happy or sad and you don't want anyone to know?*
6. *Can you give me any examples?*



**<sup>7</sup>Questions on SA in parents** (Children's perception on how their parent experiences socially challenging situations)

1. *Can you tell me about a time when Mum/Dad seemed to be very embarrassed?*
2. *How was Mum/Dad behaving in that situation? What did (s)he do?*
3. *How about an uncomfortable situation for your sister/brother? What happened? What did (s)he (sibling) do?*
4. *What does your Mum/Dad do in a situation that involves other people and makes them feel uncomfortable? Examples?*
5. *When you think about your sister/brother, what type of situations do you think they feel embarrassed in? What don't they like to do? Why?*

**Questions on ER in parents** (Children's perception on how their parent experiences emotionally challenging situations)

1. *Can you tell me about a recent situation where Mum/Dad seemed to be very upset or stressed out?*
2. *What did (s)he do in that situation?*
3. *Can you remember a situation that was very upsetting for your sister/brother? What happened? What did (s)he do?*
4. *How about a recent situation where Mum/Dad seemed to be very happy or excited?*
5. *How was Mum/Dad behaving then? What happened?*
6. *Can you remember a recent situation where your sister/brother was very happy or excited about something? What happened? What did (s)he do?*
7. *What does Mum/Dad usually do when they are very happy or sad and they have to control it? Examples?*
8. *When you have a problem do you feel like you can speak to your Mum/Dad about it? How is it?*
9. *Would you prefer to speak to your sister/brother? Why/why not?*

General Triggers:

*How did that make you feel? Can you give me another example of when you felt like this?*

*Can you tell me more about that? So why do you think you/he/she feels like this? So what do you think brought about this (the) change?*

---

<sup>7</sup> Note that the Questions on SA and ER in Parents were not included in the analysis due to space restrictions and the volume of the thesis.



### **Semi-Structured Interview Schedule (P)**

#### **Title of Research Project:**

The assessment of thoughts and reactions to certain social situations in children and their parents

#### **Example Questions:**

##### **<sup>8</sup>Questions on SA** (Parents' self-perception on their SA levels)

1. *Can you give me an example of a recent situation that was rather socially challenging/embarrassing for you? Why?*
2. *How would you describe your behaviour in that situation?*
3. *How do you generally cope in socially challenging situation? Examples?*
4. *What do you find most difficult or challenging in those situations?*

##### **Questions on ER** (Parents' self-perception on their ER levels)

1. *Can you give me an example of a recent situation that was rather emotionally challenging for you? Why?*
2. *How would you describe your behaviour in that situation?*
3. *How do you generally cope in emotionally challenging situation? Examples?*
4. *Do you feel free to talk about anything within your family?*

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<sup>8</sup> Note that the Questions on SA and ER were not included in the analysis due to space restrictions and the volume of the thesis.

**Questions on SA in children** (Parents' perception on how their child experiences socially challenging situations)

1. *What would be a socially challenging situation for your child/children? Why?*
2. *How would you describe your child's/children's behaviour in such a situation?*
3. *How does (s)he experience those? Examples?*
4. *What do you think is most difficult/challenging aspect for your child/children in those situations?*
5. *Can you describe how you deal with social or emotionally challenging issues that arise with your children?*

**Questions on ER in children** (Parents' perception on how their child experiences emotionally challenging situations)

1. *What would be an emotionally challenging situation for your child/children? Why?*
2. *How would you describe your child's/children's behaviour in such a situation?*
3. *How does (s)he experience those? Examples?*
4. *What do you think is the most difficult/challenging aspect for your child/children in those situations?*
5. *How would you describe your relationship with both your children/your child?*

**<sup>9</sup>Questions on future training programmes for children** (Parents' opinion on what needs to be included in such a programme)

1. *Generally, are you in support of training programmes focussing on emotional and social skills enhancement?*
2. *What is your opinion on which aspects need to be focussed on more/less and why?*

General Triggers:

*How did that make you feel?*

*Can you give me another example of when you felt like this?*

*Can you tell me more about that?*

*So why do you think you/he/she feels like this?*

*So what do you think brought about this (the) change?*

---

<sup>9</sup> Note that this part of the interview was not included in the analysis due to space restrictions and the volume of the thesis.

*Appendix XXV: Example Transcript of Interview with the Parent*

Interview with Linda (NG, 41 years old, female)

(Note: For the purpose of the research question and space restrictions the first part of the interview was not incorporated in the analysis. Purely the part on her perception of her son was included.)

1 I: So my name is Kati, and I am very grateful that you agreed for yourself and  
2 your child to be part of this interview, because without the help of children and  
3 parents research like this is not possible. So I really appreciate your time. I would  
4 like to remind you that the information we record and acquire from you, will  
5 only be available to the research team, which consists of the director of study,  
6 co-supervisor and myself, whereas they will probably just spot check some of the  
7 interviews to see if transcribed it properly

8 P: Right.

9 I: We all will treat this with highest anonymity and in the publication of this  
10 study, no individual results will be published, purely an overall outcome to  
11 ensure the anonymous treatment of yours and your child's individual results. So,  
12 if you could therefore give me your honest responses to the questions, in order  
13 for us to be able to establish aspects of parental and children relationship and  
14 behaviours that would be fantastic. Obviously, there are no right or wrong  
15 answers and please take the time you need to think and talk.

16 P: Yeah (smiles).

17 I: And if you have any questions at all just stop me (smiles)

18 P: Okay (smiles).

19 I: Great so there are certain social situations such as being the centre of  
20 attention or reading or speaking in front of other people that can be very  
21 challenging for children and also for adults and they may cause high levels of  
22 anxiety, worry, or nervousness and embarrassment.

23 P: (nods)

24 I: Talking about you first, on the first few questions, can you give me an example  
25 of a recent situation or long ago that doesn't matter that was socially challenging  
26 for you?

27 P: Mmm (laughs) I recently went on mm a one-day workshop actually also  
28 to do with, with m children's behaviour, it was given by mm a lady who wrote a  
29 book that I enjoyed and, and wanted to hear more about and we were all asked  
30 to give m a brief mm introduction of ourselves and what, why we were there and  
31 I, I did feel mm a bit m uncomfortable with that mainly because the majority of  
32 people there were, were quite highly qualified or where there in a professional  
33 capacity mm they were either teachers or psychologists or counsellors and I was  
34 one of the few that was sort of just there as a Mum and you know I know,

35 I: That's great though.

36 P: Yeah, I did feel a bit I suppose it's my own insecurity or issue that I felt I  
37 wasn't there with any real you know qualification or reason but, but, so that was

38 a little bit mm m awkward or I felt, I felt flashed in a way that I was now speaking  
39 in front of all these people who you know I felt were a bit more you know

40 I: Why do you think that was?

41 P: Mmm (thinks) I think properly over the last eight years while I've been  
42 in the UK I haven't really worked since having mm my, my son and I think I've  
43 lost quite a bit of confidence in myself as a, as an individual. You know my, my  
44 whole focus and role has been as a mother, that's been my sole focus and, and  
45 now that my children are a bit older and both at school I am suddenly getting, try  
46 to get back in touch with my, the rest of me who's not just a mother

47 I: Of course.

48 P: So I think I've lost a bit of self-confidence over the years and I haven't  
49 worked in the UK so I felt a little bit out of my depth here.

50 I: Yeah, sounds quite normal.

51 P: Yeah. So I worked in South Africa right up until I had Michael but that  
52 was yeah eight years ago (smiles)

53 I: Ah it's never too late

54 P: Yeah, you know I am looking at, I've just got a part-time job just doing  
55 reception work at the health clinic but it's a friend actually employed me so  
56 again it's a mm it's a little bit of a comfort zone still, but I am hoping to, to get  
57 into something you know more long term.

58 I: Yeah, absolutely. I think having that willingness is already great, that will sort of  
59 get you going

60 P: Yeah

61 I: And once you are back in there it will build up your confidence again

62 P: Yeah

63 I: But it sounds quite normal what you described. How would you describe your  
64 behaviour in a situation like that so when you feel socially challenged?

65 P: Mm I become self-conscious I, I feel I blush, I know I blush and I don't  
66 articulate very well I'll always think afterwards oh I should have said that or why  
67 didn't I say, actually I do have a valid point or, so I think I freeze up a bit and mm  
68 so yeah.

69 I: Maybe it's the pressure of the situation

70 P: Yeah, yeah

71 I: That makes sense. I blush all the time

72 P: (laughs)

73 I: I just don't stop talking and think I wish I just stopped (laughs)

74 P: (laughs) yeah you either ramble or you don't, can't say anything.

75 I: Yeah exactly.

76 P: Yeah and also on Saturday night I went to a friend's birthday party, it  
 77 was actually my friends' husband's it was his 50<sup>th</sup> and my partner didn't come  
 78 with me mm we couldn't find a babysitter at the last minute and he said oh you  
 79 go on your own, he's not very social although he's, he's great in a social situation  
 80 and he can chat to anyone he is very mm engaging and he can talk to anyone  
 81 about anything but he's just, he doesn't really like going out much so I went on  
 82 my own and again I felt a little bit m awkward and a little bit oh I don't know  
 83 what to say to this one or to that one

84 I: Yeah true, is it specially because you don't' know them or when you know  
 85 them as well?

86 P: Well you know when you know someone enough to just make light  
 87 conversation with but in a social situation, you (thinks) maybe we do speak to  
 88 someone else but you find yourself standing next to this one so you're sort of  
 89 forced to talk to them which you maybe wouldn't normally but and then you  
 90 think well how am I gonna get away now (laughs)

91 I: (laughs) that's awkward, it can be quite awkward

92 P: Yeah, yeah.

93 I: How did you mange in that situation?

94 P: Mm I guess I managed okay, mm (thinks) you know there are certain  
 95 areas that you know you quite safe to talk about whether it's the weather or  
 96 sports or kids because we know this, this group of friends through the, all our  
 97 children are at school together so I guess it's just finding some common ground  
 98 and then if it all fails just catch someone else eye and start waving at them  
 99 (laughs)

100 I: (laughs) true.

101 P: Because normally, I find normally if you feel awkward talking to  
 102 someone chances are that they probably are as well and they might welcome a  
 103 break or a way out.

104 I: Absolutely that's true. It sounds like you have that emotional awareness of it  
 105 though

106 P: Yeah I think so, although sometimes maybe it's over, over tuned you  
 107 know, sometimes you can be too worried about what you think people are

108 thinking, perceptions and that but yeah I think I, I am very in touch with  
109 emotional situations.

110 I: That's true because if it gets to intense the level of worry, that's when it starts  
111 getting inhibiting and show in your behaviour as well

112 P: Yeah, yes.

113 I: So if I was to ask you if, what sort of example you would give me for socially  
114 embarrassing situation would be similar to what you said or can you think of  
115 something where you felt really socially embarrassed?

116 P: Yeah (thinks)

117 I: Or what would be a socially embarrassing situation?

118 P: I mean these two that I described are probably more, they would only  
119 be embarrassing if I really did or said something that I thought was very crinch  
120 worthy or oh I really shouldn't have said that but at the moment, at the moment  
121 it's probably more just on an awkward level, I think if I had (thinks) you know  
122 they were passing around some party food and you know I wouldn't be really  
123 embarrassed if I, I was eating something that was really awkward to eat and I  
124 could feel it going everywhere and I suppose really obvious things like that would  
125 embarrass me, if I had dropped the whole thing or made a real mess of my, my  
126 face and hands with it mm that would have been embarrassing but I, I just  
127 managed to contain it (smiles)

128 I: (smiles)

129 P: So yeah I suppose so embarrassing would be at work I know I mm I  
130 forgot to charge someone which I was quite embarrassed about because I felt  
131 that's you know showing a, inefficacy of inadequacy in my performance. I was  
132 talking to the patient and the phone rang and while I was on the phone she left  
133 and I had forgotten to charge her and I was really embarrassed that I had to tell  
134 my boss that, so I think yeah embarrassing is either when it's really, you don't  
135 want anyone to look at you, you know, not looking your best or doing something  
136 where you are just not performing or not, not, not doing what's expected from  
137 you

138 I: It's quite self-reflecting isn't it?

139 P: Yeah.

140 I: And why do you think that is? So obviously that and what you said about  
141 obvious things that sort of look bad on you and they are quite obvious to other  
142 people

143 P: Yes



144 I: Why do you think those in particular make you feel embarrassed?

145 P: Mm well I think with instances like that mm you, you kind of what  
 146 people to have a certain idea of the kind of person you are and that, those sort  
 147 of things don't happen, I mean it's completely ridiculous those things can happen  
 148 to anyone and they do, so I guess it's just we all wanting to appear like mm the  
 149 ideal version of yourself I suppose where those things don't happen

150 I: Do you think it's the fear of humiliation or the fear of failing or what is it?

151 P: Yeah, I think the humiliation for me is, is the mm a real fear mm and on  
 152 the work front yeah if I am failing to do the job properly that I, that is, that does  
 153 worry me, you know it's not a very mm demanding job I mean I'm, I'm you know  
 154 working on reception you know taking phone calls, taking bookings, being there  
 155 for the patients when they come in to the medical centre and obviously taking  
 156 payments, it's quite straight forward really

157 (interrupted by children)

158 P: I was just talking about being able to do my job efficiently especially  
 159 not having worked for so long, now started to work again it's like oh (mimics  
 160 funny face)

161 I: Yeah, how would you describe your behaviour in those situations like for  
 162 instance when you had this awkward thing when you forgot to charge the lady?

163 P: Very, very embarrassed and mm I can be quite hard on myself mm at  
 164 times like that, like you know I'd apologise for a few times and like how can I be  
 165 so stupid and I, I realise that I am doing that and my boss was actually really  
 166 lovely and she was like it can happen, don't worry, you know we, you know she  
 167 kind of joked about it you know, you won't do it again sort of thing, but I, I kind  
 168 of beat myself up about, about things like that, that I let that happen mm which I  
 169 am aware of that I do, yeah (smiles)

170 I: (smiles) will that make it more difficult for you to make the same mistake again  
 171 or will that prohibit sort of avoid you from doing it again?

172 P: I'd like to think it would help me avoid it happening again, I don't  
 173 know.

174 I: Because if you are too hard on yourself as well you just add on to the stress  
 175 and pressure don't you

176 P: Yeah, yeah that's also true.

177 I: And how would you say you generally cope in socially challenging situations?

178 P: Mm (thinks) I would say I am quite withdrawn or, or I don't, I keep to  
 179 myself a bit more mm like in, in, in the sort of socialising with mm like the other

180 Mom's at the school on a daily basis, people you see every day I've got one really  
181 good friend and when she's there I feel more confident to talk to other people  
182 but funny enough when she's not there I've notice uh I don't know if I can talk to  
183 that one without her, I've noticed that I become more withdrawn and I, I kind of  
184 maybe a bit self-absorbed I just worry about the children and myself as supposed  
185 to enquiring how other people are, I become maybe a little bit more self-  
186 absorbed and self-content but when I am with someone who makes me feel a bit  
187 more comfortable and relaxed I feel more open.

188 I: That's interesting

189 P: Yeah

190 I: It makes sense though (laughs)

191 P: Yeah (laughs)

192 I: Some people try to cover it up by being overly confident and some people are  
193 like I am not even gonna go there

194 P: Yeah (smiles)

195 I: That's true. And what do you find most difficult in the situations that we talked  
196 about and that you described to me, what is it that you find most difficult.

197 P: I suppose being able to relate to people mm (thinks) on, on, on a level  
198 that they, you don't want to look like you are trying too hard, I just, just want to  
199 be able to relate to people in a comfortable way I think mm (thinks) yeah I don't  
200 know it's a hard one to answer (smiles)

201 I: Yeah (smiles) because they are obviously quite different situations

202 P: Yeah

203 I: But I think, I think, just listening to you, I think one of the things that became  
204 apparent is that you are quite harsh on yourself you know

205 P: Yes

206 I: And maybe that might be quite difficult for you to you know step away from  
207 what went wrong maybe or not and try to give yourself a bit of lean way

208 P: Yes, yeah.

209 I: I don't know maybe (smiles)

210 P: (smiles) no yeah that would be true to say.

211 I: I mean it's generally not nice to be in an awkward situation or sort of forced  
212 into something

213 P: Do you know some people just got a neck of being able to say the right  
 214 thing at the right time and putting people at ease and occasionally I can do that  
 215 but I would like to be able to that more when, when I am under pressure mm  
 216 because of the job I am in now mm I get to chat to a lot of different people,  
 217 every day, well I don't work, I work three days a week but I am meeting new  
 218 people every twenty minutes a new patient walks into the door and often they  
 219 want to chat and it's quite, so I am quite enjoying that aspect of it and it's quite  
 220 nice when you, cause they've come in for a medical reason and maybe they are  
 221 feeling a little bit anxious and it's quite nice to be able to, to chat with them and  
 222 maybe take their mind off what, why ever they are there. But I find it from going  
 223 back to the party the other night, I already know these people mm I like to be  
 224 able to have that ease of being able to do that with strangers with, with people  
 225 that I kind of know already (laughs)

226 I: Yeah, it's interesting isn't it, maybe it's more because with strangers it's more  
 227 superficial talk

228 P: Yeah

229 I: So its maybe easier to sort of talk about it, whereas with people that you know,  
 230 you feel a little bit more challenged to talk about something interesting

231 P: Yeah and you know you will see them again

232 I: Yeah true, I think the more you think about it consciously the more it is bound  
 233 to go wrong almost (smiles)

234 P: Yeah (smiles) and you kind of think well they will talk amongst  
 235 themselves are they all gonna say did you say what happened to her, whereas  
 236 with strangers it's like I might not ever see them again

237 I: Yeah true, so it's interesting it's more the worry about what they might be  
 238 thinking of you?

239 P: Yeah, yeah I suppose that on-going perception of, of you and you know  
 240 yeah

241 I: Yeah, sounds very natural to me (smiles)

242 P: (smiles)

243 I: It's just about how to manage it to make yourself not too stressed and anxious  
 244 in those situations

245 P: Yeah, yeah.

246 I: In terms of emotions and emotionally challenging situations people might have  
 247 different ways of actually try to regulate and cope with them so some people

248 might you know try and control their happiness or their sadness or try and  
 249 intensify or they very easily express them or some people really withhold them

250 P: (nods)

251 I: Can you give me an example of a situation that was emotionally challenging for  
 252 you?

253 P: Mm I, I had a mm not argument but discussion with my, my partner  
 254 recently about a very important matter about potentiality moving abroad and  
 255 we got into an argument or a mis, we misunderstood each other m during the  
 256 conversation and I, I found it very hard to contain my emotions, we were in a  
 257 restaurant and in fact, normally here I am not raising my voice putting myself  
 258 into that potentially embarrassing situation where people are gonna turn and  
 259 look at me (smiles) but I, I couldn't help, I couldn't stop the emotions coming out  
 260 and I, I did mm I did find it hard not to raise my voice and get, get upset mm it  
 261 didn't, didn't progress much further we were able to roll back from it but that  
 262 was unusual for me

263 I: Yeah, why do you think that was maybe because you felt it so intensely or?

264 P: Yeah I think well we've been together for a very long time, over twenty  
 265 years

266 I: Wow

267 P: Yeah so our whole adult life really and we have recurring problems that  
 268 we keep mm you know facing and we, we've identified that communication is a  
 269 problem with us and, and this particular incident was us again misinterpreting  
 270 the other one's reaction and I thought you meant that and he you know he said I  
 271 didn't say it like that so and I am like well your tone said it like that so it was just,  
 272 just a case of that, so it was a lot of frustration and only recently in the last  
 273 couple of years have we identified that we have these problems, that we had  
 274 them a long time and that we had to work on them, which is one of the reasons  
 275 why we go out now once a week to, to catch up m and so here we were in this, in  
 276 this situation we had come up with to, to help address the problem and we were  
 277 having the exact problem there and then so also it was just real frustration yeah

278 I: Would you say that's why it was so emotionally challenging for you?

279 P: Mm (thinks) yeah, I think also with the years he would always be the  
 280 one to raise his voice and m shout and I, and I always wen the other way I either  
 281 cry or just not say anything and in the last probably year or so I've tried to get  
 282 more in touch with how I actually feel, cause I think I suppress a lot of how I feel  
 283 and now, now that I've got in touch with what I am actually feeling it is coming  
 284 out more, which, which surprises me.

285 I: Yeah, it's probably a change for him as well (smiles)

286 P: Yes, yeah, no and he has acknowledged that and overall it's a good  
287 thing but yeah (laughs)

288 I: It's difficult to identify certain feelings that you feel but I think the first thing  
289 forward is to be able to express them.

290 P: Yeah.

291 I: Sometimes it might be quite intense I suppose, especially when you express  
292 them, especially to the other person, as they might not feel the same way

293 P: Yeah

294 I: But yeah sometimes acknowledging all that is the best way forward isn't it, it's  
295 really good.

296 P: Yeah, yeah.

297 I: And how would you describe your behaviour in emotionally challenging  
298 situations I mean actually you already answered that, so am I right in assuming  
299 that first you, a few years ago maybe you suppressed them more and now you  
300 are more open about them?

301 P: Yeah, yeah, before I think I would keep it all inside I think even going  
302 back to childhood I realise now I kept a lot of things inside and not only that I  
303 didn't share them with anyone but I don't think I was really good in  
304 acknowledging them to myself I don't think I mm put enough value on them and  
305 you just kind of ignore them mm so I think over the years I've began to recognise  
306 them and maybe share them either with my Mom or with a close friend but only  
307 now you know, forty one years later (laughs) they are starting to come out.

308 I: (laughs) and how does that make you feel?

309 P: In a way it's quite empowering mm (thinks) it's also quite scary mm I  
310 am not used to that and there is also what do you do with them when they come  
311 out

312 I: Yeah

313 P: You know, now they are there, cause I am, I am much more of a  
314 reactive person than proactive and if they come out and then you're not gonna  
315 do anything about them, you kind of are in a worse of place, cause you are just  
316 sitting with them you are not doing anything about them mm my partner is very,  
317 if something is broken you fix it, if you are not happy with that you go and do  
318 something about it

319 I: (laughs) problem focussed

320 P: Yeah (smiles).

321 I: Solution focussed I mean

322 P: Yeah very much so.

323 I: Sounds like you balance each other out though (smiles)

324 P: Well I, I think, that's how we got together in the first place but I think  
 325 over the years we've gone even more extreme and it's trying to find a little  
 326 ground (laughs)

327 I: Yeah true, but I think the willingness and recognition is the most important first  
 328 step

329 P: Yeah, yeah, well I think we've realised we have to make real effort and  
 330 change because otherwise we will just fall apart completely.

331 I: God relationships are so difficult

332 P: Yeah they are.

333 I: Twenty-one years though that is amazing.

334 P: Yeah, we met when we were twenty and but also the children are a  
 335 massive part of that, I think we might, might have you know waved the white  
 336 flag if it wasn't for the kids and said okay, but no we've got very good incentive  
 337 to work it out so yeah.

338 I: Ah that's fantastic. Do you feel free to talk about anything within your family

339 P: You mean, my, with him, like my immediate family or with my parents?

340 I: Yeah immediate family.

341 P: I feel like I do have a, a bit of a distinction between my, my partner, my  
 342 kids and I as in my immediate family and my family back in South Africa which is  
 343 my Mom, my Dad, my brother, his children, I feel mm that, he, they don't have  
 344 enough significance mm to him, to my partner so I do, do, I feel like I can always  
 345 talk to him about my family back home because I don't feel like he puts enough  
 346 importance on them, but in terms of things that affect the children and I, I think  
 347 yeah I can talk to them about most, most things mm but the problem is, he  
 348 always wants to find a solution so sometimes you don't want that, so I might not  
 349 tell him everything that's on my mind or worrying me because I don't want, I  
 350 know what he's gonna say (laughs)

351 I: So do you then go to you know to your other family

352 P: Family or friend, yeah

353 I: That's good so you do feel like you want to talk to somebody?

354 P: Yeah, yeah, it's funny being here because I got my very best friends  
 355 back home so there is no one here that I've known since I was a child, I am sure  
 356 you, you are in a similar situation (smiles)

357 I: Yeah (smiles)

358 P: So you got close friends here that you can share some things with

359 I: I yeah but it's not the same

360 P: Yeah it's not the same (laughs)

361 I: I can completely agree with that (smiles) I can completely emphasise with that

362 P: Yeah

363 I: And it just does sometimes make you feel lonely although you are not

364 P: Yeah

365 I: And you haven't been it's not the same closeness

366 P: Yeah it does, it does, definitely

367 I: It's quite conflicting

368 P: Yeah. And the hard thing is, he, I would think he's in the same situation  
 369 but he doesn't feel that, he doesn't feel mm cut-off or he doesn't really want to  
 370 share, he, he's a completely different person to me. He's got one best friend  
 371 back home and they talk for hours every now and then and that's enough for  
 372 him

373 I: It's the difference in men and women isn't it (laughs)

374 P: Yeah I think so (same).

375 I: That's true. Thank you so much for sharing the information about yourself, this  
 376 part now is about your children

377 P: Yea, okay.

378 I: So children generally go through diverse stages in life experience socially or  
 379 emotionally challenging situations, usually it seems 'normal' to parents when  
 380 children feel nervous, in particular situations or embarrassed but as I said earlier  
 381 sometimes it can be quite intense and lead to quite inhibiting or quite sever  
 382 levels of embarrassment.

383 P: Yeah.

384 I: What would be a socially challenging situation for Michael?

385 P: Mmm (thinks) although he's quite confident and out-going I think mm  
 386 it has to be in a, in a mm area that he's comfortable in so mm that is with, with,  
 387 probably with people that he knows very well, so like recently he, he did a  
 388 reading at the Easter Service in front of the whole school and I know for him that  
 389 was a challenge but he, he could have said he didn't want to do it and he didn't,  
 390 he took up the challenge.

391 I: Brilliant.

392 P: But he was worried about it.

393 I: Ah why do you think that was?

394 P: I think he was worried that he would get the lines wrong mm and even  
 395 in these class assembly he did a project on Egypt and he had I think one or two  
 396 lines to say and he was worried that he'd pronounce the one word wrong and  
 397 funnily enough he did, he did get it wrong (smiles) but the whole, everyone  
 398 laughed, everyone in his class laughed because it becomes such a thing every  
 399 rehearsal he kept getting the line wrong, but because he, he kind of saw a funny  
 400 side of it as well it kind of defused it, but initially he was quite, quite anxious  
 401 about it.

402 I: And do you think it's again so challenging because he feels he's going to  
 403 embarrass himself or is it the fear of failure?

404 P: I think embarrassing himself and people laughing at him and yeah  
 405 maybe from the teacher's perspective not being able to do what she asked so a  
 406 bit of both maybe.

407 I: True, yeah that makes sense

408 P: Yeah cause I think he, he's that kind of child who wants to please

409 I: Aw (smiles)

410 P: Do you know what I mean (smiles)

411 I: Yeah (smiles)

412 P: He is still at the age where he wants to the right things, he's not, he's  
 413 not quite oh I don't care I am too cool, he does want to get things right

414 I: That is brilliant, I mean well done for still doing it, although he feels nervous  
 415 about it

416 P: Yeah, yeah I am proud of him (laughs)

417 I: (smiles) and how would you describe his behaviour in such a situation?



418 P: Well leading up to the church service he was very nervous, I could see  
 419 his hands were sweaty and he was fidgety and he was I think he just wanted to  
 420 get it over with mm but he was excited (smiles) I think there was sort of positive  
 421 excitement in him as well but I could see he was like (imitates worried face)

422 I: (laughs) that's so normal

423 P: Yeah, yeah (smiles)

424 I: And also a bit healthy to be a bit nervous it makes you perform better

425 P: Yeah, yeah.

426 I: How do you think he experiences those situations himself?

427 P: Mm I think he probably mm in his mind they are probably bigger than  
 428 they are mm (thinks) but I think overall he's, he's fairly secure in that either he  
 429 can do it or if he can't it, it won't be that bad I think. I think he's got some level  
 430 of mm comfort, I like to think so anyway

431 I: Yeah

432 P: I don't think he would run out of the room crying or anything do you  
 433 know what I mean I think he, although he did, he is just starting football practice,  
 434 his best friend wanted him to do it and my, my partner is a big Rugby fan he is  
 435 not into football at all, we've lived in the UK for eight years, we don't watch  
 436 football, we don't know who the teams are, which is quite a big thing

437 I: Yeah in England especially (smiles)

438 P: (smiles) yeah and now the kids mm in year three are all in this team  
 439 and so he feels I think a bit cut-off from them because he's got no idea what they  
 440 are talking about and he says well I like Rugby, anyway his best friend said come  
 441 to, we're gonna play football why don't you come with me, and he, again he  
 442 didn't wanna go and his friend managed to persuade him and he went, and I  
 443 went to watch and for some reason they made him be the goaly and he was  
 444 standing there and the ball came towards him and he didn't know what to do  
 445 and one time the ball actually hit him and, and then the ball went back on the  
 446 field and he just turned his back and I knew he was crying and his friend saw and  
 447 called the coach over and I think he just pretended that the ball hurt him but I  
 448 don't, I don't think it really hurt him I think he, he's just, he felt, he didn't know  
 449 what to do, he was under pressure and then funny enough on the way here  
 450 today we drove past Marble Hill Park and he said that's where I did football and I  
 451 said yes do you want to go back and he said I don't know the ball hit me and all  
 452 the other team mates shouted at me because I let the goal in

453 I: Ah it really isn't a nice experience

454 P: Yeah I hope he gives it another go

455 I: I hope so just so that he's sort of not traumatised by the first one

456 P: Yeah, yeah

457 I: Ah bless him (smiles)

458 P: So yeah (smiles) he didn't really know how to handle that, I think if he  
 459 could have run off he probably would have, but I am glad he didn't and he, he  
 460 had enough strengths reserved to know I've got to stand this out (laughs).

461 I: (smiles) yeah and he even sort of turned around and tried to cover it up

462 P: Yeah, yeah.

463 I: A coping mechanism in itself (laughs)

464 P: (smiles) yeah.

465 I: That is brilliant he didn't give up

466 P: Yeah

467 I: What do you think, is the most challenging aspect for him in those situations  
 468 that are quite socially challenging?

469 P: Mm (thinks) I think, I think probably hiding how he feels cause he does,  
 470 he does let his emotions out quite easily, he, he will cry or get upset but I think  
 471 he, then he didn't want the other boys to know mm so I think he, he finds it hard  
 472 to, to deal with his emotions to know what's the right reaction to let out their  
 473 you know yeah, even at home when he gets frustrated about something he'll go  
 474 up in his room and slam the door I think that's his way of you know not, not  
 475 dealing with it there and then, he wants to go off and maybe think about it or  
 476 calm down and that he does on his own. And then afterwards he, he, he's happy  
 477 to talk about it in quite detail

478 I: That's good

479 P: Yeah.

480 I: That's good that he knows that he has to just distance himself to then be able  
 481 to reflect on it

482 P: If he just didn't slam the door (laughs)

483 I: Yeah that's true (smile) well hopefully with age he will find a way to control it  
 484 better, it's difficult

485 P: (nods)

486 I: I think especially for a child feeling quite intense feelings and knowing how to  
 487 react

488 P: Yeah

489 I: Let alone for boys I think

490 P: Yeah, yeah

491 I: But that's good it sounds like he's got that level of maturity in him

492 P: Yeah I think so.

493 I: Can you describe how you deal with socially or emotionally challenging issues  
494 that arise with your children or with Michael in particular?

495 P: M you mean how I deal with it with him?

496 I: Yeah and within yourself as well.

497 P: I mean you know thinking of the church scenario and the football  
498 scenario I, I definitely I mean part of me would want to run and give him a big  
499 hug obviously, I wouldn't do that to him (laughs)

500 I: (laughs)

501 P: Mm I think I, I do just also trust or believe somehow that he will be  
502 okay mm and you know try and catch his eye or send him some kind of sign that I  
503 know he is alright and everything will be alright, reassurance.

504 I: Yeah that's brilliant. And are you worried within yourself?

505 P: Yes, yeah obviously you know you don't want to see them fail or be in a  
506 situation that they are uncomfortable although my partner will always say that's  
507 good for him that's a growth opportunity and you know (laughs)

508 I: (laughs) that's good that's why you are the Mum and he is the Dad.

509 P: Yeah (smiles).

510 I: Okay. And in terms of emotions what would be an emotionally challenging  
511 situation for Michael?

512 P: (thinks) Mm I tell you what does happen quite often is his dad on the  
513 weekend will say come we're going out for a bicycle ride and but because he's  
514 got, he's, he's very no nonsense and he will even when it's cold mm and not nice  
515 weather he will still say we're going on a bicycle ride and it will be like a two hour  
516 ride and, and Michael sometimes doesn't want to go or maybe we discussed  
517 doing something together at home or playing, or go visit the neighbours or  
518 something and then he'd be in the position where he's got to make that choice  
519 and he's, he's very aware of letting me down or his Dad down, he, and I can see  
520 he, he's, he will just well up and he's like if he, his Dad goes well if you don't  
521 wanna do it with me that's fine just say so, so I think it's a guilt and, and he says

522 I'm not trying to make you feel guilt but you decide you know, which is, kids are  
 523 always going to do that, they're always going to think that it's their fault and I am  
 524 very aware of that and I think you know my partner doesn't see it that much and  
 525 he just says he needs to be old enough to make a decision and he's not gonna  
 526 hold it against him but I think kids do and he battle with that, he, he battles with  
 527 letting someone down or saying no

528 I: Ah

529 P: Yeah

530 I: Aw he sounds quite empathetic for his age

531 P: Yeah (smiles)

532 I: Aw bless him

533 P: I know he has a problem with that

534 I: How would you describe his behaviour in those kinds of situations, when he is  
 535 so emotionally challenged?

536 P: I think he's, he's, m he'd be really torn, he won't know what to do, he'd  
 537 also be probably flushed, he'd be crying mm you know I see, he thinks oh I better  
 538 go and he puts his stuff on and I can see that, that, the tension or the pulling  
 539 him, you know, oh I really don't wanna be doing this, but he doesn't know what  
 540 the right thing is, he wants someone to just tell him what the right thing is to do.

541 I: It is sometimes quite hard especially when they are empathetic and worried  
 542 about other people they feel like it's choosing between Mum and Dad and that  
 543 can be quite difficult

544 P: Yeah, and his Dad will go well he you must do what's right for you and I  
 545 think he doesn't always know what that is you know he still thinks it's right for  
 546 him to do what's gonna make his Dad happy even if he wants to go play with the  
 547 neighbours

548 I: And what would he do?

549 P: He normally will go, he normally will go, yeah

550 I: Aw bless his heart (smiles)

551 P: Yeah (smiles)

552 I: So do you think it's quite, does he experiences this in quite a negative way?

553 P: I think sometimes he does, yeah, because he's, he's making someone  
 554 else's feelings his responsibility, which you know you kind of teach them, you  
 555 know you gotta be aware of each other's feelings and don't hurt each other's

556 feelings but in the end of the day if someone chooses to be angry or annoyed  
 557 with you cause you did what you wanted to do, it's such a fine line you know

558 I: Yeah that's true and we don't even get that right, let alone children

559 P: Yeah, yeah. And then sometimes his Dad will be so annoyed that he  
 560 didn't just jump at the opportunity to go and do that with him that he won't take  
 561 him anymore and then he feels even worse

562 I: Yeah of course.

563 P: See now I've really upset him, no I, you know so mm I think he really  
 564 battles with that.

565 I: Sounds like that. What do you think is the most challenging aspect in those  
 566 sorts of situations for him?

567 P: I think the challenge is, is mm for him to, to just be responsible for his  
 568 own feelings and not, and not, and realise that he can't, it's not up to him how  
 569 we, how I react to what he just said or how he Dad choses to react.

570 I: Do you find that he is similar with his friends or is it just really with his Dad?

571 P: Mm I think he's got a stronger desire to please his Dad mm I think with  
 572 his friends mm (thinks) he, he's quite good at pleasing his friends on, cause I  
 573 think they're easier, they've got a more, like if they're playing a game and his  
 574 friend wants it to be a certain way, he'll kind of make, he's very good in not  
 575 manipulating but even with Willow he'll, he'll make that other person feel like  
 576 they're getting a bit of a deal out of it as well, he's quite a deal maker

577 I: Ah smart (laughs)

578 P: (smiles) yeah no he is. So he'll, he's got a way of getting the result he  
 579 would like with other people still feeling like they've you know not lost out  
 580 completely.

581 I: Ah that's fantastic, so it almost sounds like he doesn't find it challenging, you  
 582 know more challenging with his father really

583 P: Yeah

584 I: Because with the other's he is sort of, he is still worried about what they feel  
 585 that's why he is trying to please them as well

586 P: Yeah, yes

587 I: He can then make them feel they're getting something out of it but still getting  
 588 what he wants

589 P: Yeah, I think cause you know his Dad is very black or white, no  
 590 nonsense, whereas his friends and Willow they, and they always look to him for  
 591 what game are we gonna play or how are we gonna do this, you know they know  
 592 that, that's, that is his style and his nature, so I think he's comfortable with that,  
 593 yeah.

594 I: That's fantastic, that's really, really good.

595 P: Yeah

596 I: How would you describe your relationship with both your children?

597 P: Mm we're very, very close mm my partner says I molly cuddle them  
 598 much too much, so we are very close, I think when we moved to the UK and we  
 599 didn't really know anyone and Michael was 8 months old, he, we really bonded  
 600 because you know my partner was working every day and I was with Michael  
 601 every day and I wear one of those, cause we lived in central London where  
 602 buggies are tricky so he was literally like a little koala bear and we went  
 603 everywhere together and you know we went to parks and my whole focus was  
 604 him to be honest I really, I didn't have my family, my friends around, or my job  
 605 anymore so I think he and I are particularly close and we're quite similar in  
 606 nature and mm Willow is a lot more like her Dad (smiles) we're also very close  
 607 and she, she's quite jealous of, of, if Michael, she's always, like at meal time her  
 608 chair will attach my chair so she's, she feels mm she got to be very close to me all  
 609 the time but we have more of a, a bit of a personality clash in a way, cause she is  
 610 very dominant character and quite stubborn and even my partner has pointed  
 611 this out, and he's quite right, she, she likes to have control over me so at bed  
 612 time she will, she will keep calling me and this is wrong and I need this and I need  
 613 that, cause she just wants me to come back and be with her and she's find a way  
 614 to do it by appealing to my you know motherly instincts if you like, which is  
 615 natural I think they do learn to do that at a very young age and then if I get angry  
 616 with her, her saying that she always says is Mama be happy, ah mami (imitates)  
 617 she doesn't like me to be angry with her and, and you know when, when like in  
 618 the morning when she doesn't want to get dressed or put her shoes on and  
 619 we're late for school and I say you gotta get ready so we can go now, she'd be  
 620 like Mama be happy and I am like I will be happy if you just put your shoes on so  
 621 we can go, so, so we do knock heads more than Michael and I did, I don't know if  
 622 it's because we're both females or completely different personalities.

623 I: Yeah I think it's also the whole Mother and daughter kind of thing

624 P: Yeah, yeah, but I was so hoping when I was pregnant the second time I  
 625 really, really was hoping for a little girl mm so you know I, I just, I, she's very  
 626 cuddly as well and when we have moments where we hug and cuddle I just, I  
 627 also have a very, very close bond with her even though we have you know a  
 628 challenged

629 I: Yeah it's all part of it, I had the same sort of thing with my Mum

630 P: Really (smiles)?

631 I: Yeah and we are very close, and it sounds cheesy but all is based on the  
632 foundation of love, of a loving relationship

633 P: Yes

634 I: Cause personalities are always different and they can always clash

635 P: I think she, she's probably like her Dad, likes more order and structure,  
636 whereas Michael is happy with the more free flow style m so I think I need to  
637 adapt my parenting style to her with Michael he and I just naturally worked,  
638 whereas I need to give Willow a bit more m structure I think yeah.

639 I: It seems like you are very aware of it all though, so that's good.

640 P: Yeah but again it's being proactive and acting on it, I mean it's, it's hard  
641 to not, to just slip back in my normal way of doing things.

642 I: Yeah of course, because that's what comes natural to you, absolutely

643 P: Yeah

644 I: But again, the acknowledgement is the first step forward

645 P: Yeah.

646 I: Fantastic and they both seem so lovely (smiles)

647 P: (smiles) thank you.

648 I: So we are just coming to the end actually

649 P: Alright

650 I: In terms of future training programmes for children, are you generally in  
651 support of training programmes focussing on emotion and social skills?

652 P: Yes, yes I mean that is one of the reasons that I was interested in this,  
653 because I was m reading up about mindfulness mm I don't know I think we  
654 discussed it briefly and there is a organisation in the UK called Dotbe it's  
655 mindfulness in schools and they're piloting it in a few schools were they are also  
656 letting children to, sort of short meditation practices during the normal school  
657 curriculum but it's taught by their normal teachers so it's really incorporated into  
658 their day and also they just take sort of ten or twenty second break to quickly  
659 realise what they're feeling and where they're feelings it you know that physical  
660 sensation which I just think is so important for children to to translate their  
661 emotions to, to physical aspects and then how to deal with that, so I am very, I  
662 am very mm in favour of that sort of thing, because I, you know it's, it's so

663 important to do, know how you are feeling and being aware of how you're  
664 feeling and how they can help you cope and, and, and in the talk I went to they  
665 did speak about emotional resilience and how it is something that isn't trained  
666 and how, they had also done a study with two groups of children, they gave  
667 them a problem to solve and the one group of children mm when they solved  
668 they were told oh you are so clever that you did that and well done and the  
669 other group mm they got a different feedback they were like oh well you worked  
670 really hard to find the answer you got and you managed to succeed and then  
671 given the next problem the first group who were told that they were so clever  
672 that they got it, didn't get as good a result as the second group who were told  
673 that they had worked well together and managed to work it out, you know. It  
674 was just interesting how m and they said you know the whole emotion resilience  
675 thing you know giving children the mm the confidence to do what they can, to  
676 keep trying you know and not just label themselves as one thing or another, so  
677 yeah

678 I: That is so true and like you said as well to sort of familiarise with bodily signals  
679 you know to feel comfortable

680 P: Yeah and I think children are under so much pressure today than we  
681 were as children you know in terms of getting the right results, fitting in socially,  
682 you know the world has changed a lot and I think they, they need to be given  
683 mm tools to help them cope with this, cause you know they are living in a  
684 different world now (laughs)

685 I: Yeah it's true and it's almost like life skills

686 P: Yeah

687 I: Yeah and it's not a given

688 P: Yeah and they've got a lot more to deal with at a younger age

689 I: Exactly and they grow up so much faster in a way as well, so be able to apply  
690 these skills would be helpful

691 P: Yeah.

692 I: And what aspects do you as a parent think need to be focussed on more or  
693 mostly?

694 P: Mm (thinks) I, I think definitely what we've just spoke about that  
695 emotional resilience that, that mm that believe in themselves that they can  
696 actually, they've got all of what they need inside themselves to cope with most  
697 things and to identify what those feelings are so that they you know they can  
698 label how, how they're feeling in certain situations and then they can maybe you  
699 know once they've identified how they feel it's easier to address really

700 I: Absolutely.



701 P: Yeah

702 I: It starts very simple if you can name it, then it's easier to identify and

703 P:

704 Yeah it's much scarier when you don't, when you can't name it and you don't

705 know what it is or why it's happening

706 I: Yeah

707 P: And they often I think as kids think that they are the only one ever to

708 feel that and they don't you know not being more aware that you know if you're

709 doing it in the group for them to share that other children are feeling the same

710 way or maybe they feel something else and that's why they act a certain way,

711 the awareness that we, we're all people with different feelings and reactions and

712 I think that really can help them with everything, yeah

713 I: Yeah exactly it makes it more okay and automatically boosts their confidence

714 P: Yeah

715 I: It's like a cycle isn't it

716 P: Yeah, yeah.

717 I: Have you got any questions, anything you would like to ask or anything you

718 would like to add?

719 P: Mm I don't think so, no I mean just I'd be curious to hear how this

720 proceeds, that's all really, yeah

721 I: Absolutely I will keep in touch with the results

722 P: Okay (smiles)

723 I: Thank you so much, this is the end of the interview

724 P: You are welcome, okay

725 I: Thank you for all the information you provided (smiles)

726 P: You are welcome (smiles)

*Appendix XXVI: Example Transcript of Interview with the Child*

Interview with Michael (NG, 8 years old, male)

(Note: For the purpose of the research question and space restrictions only the first part of the interview was incorporated in the analysis. Solely the part on his perception of himself was included.)

1 I: Right, so as you know my name is Kati and I work with children in different schools.  
2 I am trying to find out how children in your age feel and react in certain situations to find a  
3 way to help children in uncomfortable situations, you know like for instance when they feel  
4 embarrassed or nervous or something like that. So I would like to ask you a few questions  
5 and it would be great if you could just tell me about yourself and how you felt and reacted  
6 in those particular situations. And then just remember that this is not a test so there are no  
7 right or wrong answers, okay, I am just interested in your genuine response. I just want to  
8 see how boys in your age feel about certain situations. And I won't tell anyone about this  
9 interview either, I am just recording it so I can type it up later alright.

10 P: (nods)

11 I: Okay so some children are very nervous sometimes when they have to talk or do  
12 anything in front of other people and they feel easily embarrassed and generally worried in  
13 situations that involve new children, children they already know or even adults. Can you  
14 give me an example of a recent situation when you were very embarrassed about  
15 something?

16 P: Mmm (thinks)

17 I: Maybe in schools or in sports or play day? Any situation where other people were there  
18 and you felt embarrassed?

19 P: Mm I am not sure (smiles)

20 I: Maybe at school or at a play or when you had to read something in class or  
21 anything?

22 P: Oh yeah, we did a Easter service and I had to say some lines in front of the whole  
23 church, in front of all the juniors, in front of everyone's Mum and Dad and I was  
24 embarrassed and scared.

25 I: Wow. And why were you embarrassed or scared?

26 P: Because I was the only one standing up in front of the microphone (smiles)

27 I: Oh wow you are brave.

28 P: And I had to say four long lines.

29 I: Well done. And why do you think you felt nervous or embarrassed?

30 P: Because I thought that I might say something wrong and everyone would laugh at  
31 me.

32 I: It is quite embarrassing when people laugh at you isn't it.

33 P: Yeah (nods)

34 I: Well done. And you did it?

35 P: Yeah (nods)

36 I: And how was it?

37 P: It was okay (smiles).

38 I: Yeah, so when you did it you didn't feel embarrassed anymore?

39 P: No.

40 I: Because it went well?

41 P: Yeah.

42 I: Ah, okay and what do you do in a situation when you feel really embarrassed?

43 P: M if my Mummy is there and we are allowed to go to my Mummy, I go and cuddle  
44 my Mummy or hide or just run to my Mummy (smiles)

45 I: Okay, what if she is not there?

46 P: Then I just carry on whatever I was doing and then when I finished I just go and  
47 hide somewhere.

48 I: Brilliant so you try and cope with the situation but you like to hide when you feel  
49 embarrassed?

50 P: Yeah (nods)

51 I: Why is that, is it because you don't want other people to see or why?

52 P: I just feel safer there.

53 I: Yeah, that makes sense. And can you tell me about a situation, maybe something  
54 recently where you felt uncomfortable because other people were around you?

55 P: Mm no.

56 I: No, like for instance let's say you can't hide when you feel embarrassed or  
57 uncomfortable and other people are around you, would that be quite uncomfortable for  
58 you?

59 P: A little bit.

60 I: And what do you do then? How do you behave?

61 P: M I just stay quiet until someone asks me a question.

62 I: And then do you answer?

63 P: Yeah.

64 I: Okay and what do you find most difficult in an embarrassing or uncomfortable  
65 situation?

66 P: Mm (thinks) coping with it.

67 I: Yeah it is difficult isn't it

68 P: (nods)

69 I: Yeah I find it difficult too. Okay some children find it hard sometimes to show their  
70 feelings like for example when they are happy, sad, or angry, and some find it difficult to  
71 hide. Sometimes these reactions completely depend on the situation and the actual feeling  
72 that they feel. Can you give me an example of a recent situation when you were very upset  
73 or stressed out?

74 P: Mm (thinks) mm

75 I: Something that really upset you maybe?

76 P: (thinks) when my Mummy gets sad or angry at me or when my Mummy shouts at  
77 me or when my Mummy and my Daddy shout.

78 I: Yeah

79 P: Yeah.

80 I: That really upsets you yeah?

81 P: (nods)

82 I: And what do you do when you are so upset or stressed out?

83 P: I just go and sit on the coach and (thinks) hide under a blanket and think about it  
84 and think about how I can make my Mummy happy.

85 I: Ah that's really sweet of you. That's really nice. Can you think of anything else that  
86 might make you upset or stress you out?

87 P: Mmm (thinks) when my sister does something that I don't want her to do (smiles)  
88 or when she gets to do something that I don't get to do.

89 I: What do you do then?

90 P: Then I ask my Mummy if I can do it too and then wait what the answer is.

91 I: Okay and what if you don't like the answer, what do you do then?

92 P: Then I just, do what I am supposed to do (smiles)

93 I: (smiles) you are a good boy, brilliant. And can you remember a time when you  
94 were very happy or excited about something?

95 P: When my Mummy and Daddy told me that we are going to a surprise holiday and I  
 96 didn't know where we were going.

97 I: Ah cool! That is nice.

98 P: And then I kept on guessing in alphabetical order all the countries and finally I got it  
 99 right and we were going to Thailand (smiles)

100 I: Ah that is amazing (smiles)! So have you been already or are you going to?

101 P: No I have been, I went for Christmas and the Christmas before.

102 I: Ah lucky you, how was it?

103 P: It was very nice (smiles)

104 I: Yeah did you really like it?

105 P: The problem was all of us got sick, because the weather was very hot and Mummy  
 106 said because we changed from very cold weather to very hot weather it made us not feel  
 107 well.

108 I: Yeah that's true, that makes sense.

109 P: And I got plane sick.

110 I: Oh no.

111 P: But other than that it was very nice (smiles)

112 I: Yeah and you were very happy.

113 P: Yes (smiles).

114 I: Ah great and what do you usually do when you are very happy?

115 P: I bounce up and down and I cuddle my Mummy lots (smiles)

116 I: Ah that's so sweet. So do you show it easily?

117 P: Yes.

118 I: And what do you usually do when you are extremely happy or very, very sad and  
 119 you don't want anyone to know?

120 P: Mm it's actually quite hard to not show it.

121 I: Both sad and happy?

122 P: Mm I don't really show sad easily but I can show happy easily (smiles)

123 I: Yeah so it's more difficult to hide the happy feelings?

124 P: Yeah.

125 I: So is it easy for you to hide the sad feelings?

126 P: Mm (thinks) yeah.

127 I: Yeah do you find it easier to hide?

128 P: Yeah

129 I: I wonder why, can you give me an example maybe when you were very happy or  
130 very sad and you tried to hide it because you didn't want anyone else to know?

131 P: When I was playing my first goal at playing football and the ball came and I didn't  
132 know what to do and then it got in the other goal and then everyone shouted at me and I  
133 got really sad but then I didn't want to show it.

134 I: So what did you do?

135 P: I just went off the pitch and played with my other friends who weren't playing  
136 football.

137 I: Okay and did that cheer you up?

138 P: Yeah (smiles)

139 I: Okay, well done, that's okay a lot of goal keepers get a ball in sometimes you know,  
140 it's not nice for people to shout at you.

141 P: No.

142 I: So if you want to you can hide it you think?

143 P: Mm sometimes if I, if I have to carry on playing like if I go to football lessons and it,  
144 and if I do that then I can't really go of the pitch so I have to hide it.

145 I: Brilliant and you stay on the pitch, fantastic. Okay very well done so far, we are half  
146 way through and you are being a great help, thank you. I just want to ask you a few  
147 questions now on your parents and your sister and how they react in certain situations.  
148 And gain please don't worry I won't tell anybody. So sometimes even adults get really  
149 worried or embarrassed in situations. Can you tell me about a time when Mum seemed to  
150 be very embarrassed?

151 P: Mm (thinks) when she was doing a big talk in front of, when she goes to meditation  
152 class on Mondays and she told me she had to do a big talk about herself at her meditation  
153 class and she said that she was very, very embarrassed if she got something wrong and  
154 nervous but she didn't get anything wrong.

155 I: Ah well done.

156 P: Even when they went and asked her questions about it.

157 I: That's really good. Can you understand why she is embarrassed in those situations?

158 P: Well I also done something like that and it is very scary because she might get  
159 something wrong and then everyone laughs at you and then you don't feel good, so she  
160 must have felt like that.

161 I: Yeah it seems so, I understand. Okay and how was Mum behaving in that situation  
162 or what does she do when she is very embarrassed?

163 P: Mm she talks to me about it or I go and cheer her up (smiles)

164 I: (smiles) that is so sweet of you. Does it help?

165 P: Well if my sister does it with me then it does (smiles) if we both do it.

166 I: Ah that's fantastic. And how about an uncomfortable situation for your sister?

167 P: When she has to go to her karate lesson and she doesn't want to because we don't  
168 really want to go to karate lessons.

169 I: No, why?

170 P: Because we have to go there very Saturday, Sunday and Tuesday

171 I: Wow that is a lot.

172 P: So it is quite tiring so we sometimes don't wanna go, so when it's one of our  
173 birthdays or we have to go to someone's party then we don't go (smiles) and then we are  
174 very happy.

175 I: So do you think it's just tiring for her or that might be uncomfortable situation for  
176 her?

177 P: I think it's just that. She just wants to stay at home and watch TV or play with her  
178 dolls.

179 I: Of course and what else doesn't she like to do because maybe it makes her feel  
180 embarrassed or uncomfortable?

181 P: Mm sometimes she doesn't like brushing her hair and that makes her feel really  
182 not comfortable and she doesn't like putting on her ballet clothes and she has to go to  
183 ballet classes so sometimes she doesn't do ballet and she sometimes, when I get to do  
184 something like go to some a bigger boys party that's really fun like rock climbing or  
185 watching a movie then she gets a bit jealous and uncomfortable.

186 I: Really, ah, and what does she do?

187 P: She goes and asks my Mummy can I go with him and my Mummy says no but you  
188 might be able to go to someone else's party and have the same thing.

189 I: (smiles) ah it's probably because you are her bigger brother hu and she loves you.



190 P: (smiles)

191 I: And when Mum is with other people and seems embarrassed or uncomfortable  
192 what does she do?

193 P: Mm I am not really sure because I never really see her doing, doing that because  
194 she always goes out a lot so I don't really see what she does, but if I knew what she would  
195 do I would think that she would come to talk to me or my Daddy about it and we would do  
196 something to sort it out.

197 I: Yeah, fantastic, that's really good. And when you think about Willow your sister  
198 what type of situations do you think she feels embarrassed in?

199 P: Also when she is speaking into a microphone on her own and everyone is watching  
200 her. It's, that's the kind of situation she gets embarrassed in.

201 I: Do you think it's the same reasons why you and Mum get embarrassed?

202 P: Yeah. They might laugh at you.

203 I: Okay is there anything else she doesn't like to do?

204 P: Willow or my Mummy?

205 I: Willow?

206 P: Mm (thinks) she doesn't like to watch Rugby with my Daddy but I do (smiles) and  
207 sometimes she just wants to take the remote and turn it off.

208 I: (smiles)

209 P: But she is not allowed to.

210 I: Of course not. And can you tell me about a time when Mum seemed very upset or  
211 stressed out about something?

212 P: When my godmother died and my Mummy was very unhappy because that was  
213 her grandma and it was my Godmother so we were all very sad.

214 I: Of course. And what does she do when she's really upset?

215 P: She cries and goes and sits on the coach and thinks about it like me.

216 I: Ah, and can you remember a time that was very upsetting for Willow, and what  
217 happened then?

218 P: Mm no, not really (thinks) when (thinks) when my Daddy said that I am going to  
219 change the channel to Rugby (smiles)

220 I: (smiles) what does she usually do when she's upset about something, does she cry  
221 as well or what does she do?

222 P: Yeah she also cries and goes and hugs Mummy (smiles)

223 I: (smiles) okay how about a time when Mum seemed to be very happy or excited?

224 P: When she won the you know these things that you get on the radio where you  
 225 have to phone to the radio station and win something (smiles) she won one of them to go  
 226 and see Robin Williams and she really likes Robby Williams so she was screaming and very  
 227 happy (smiles) and then she won another one where she got to go and see a movie, the  
 228 Sweeny, and she said it was a very good movie.

229 I: Yeah I watched it too, it was very good. That's so cool, what does do when she's  
 230 very happy or excited?

231 P: She jumps up and down and screams and claps her hands like this (reacts mum  
 232 clapping)

233 I: (laughs) so can you easily tell when Mum is happy or sad?

234 P: Yeah

235 I: Yeah, she easily shows both?

236 P: Yeah.

237 I: Okay and can you remember a time when Willow was very happy or exciting about  
 238 something?

239 P: When (thinks) mm a friend gave her lots of Barbie clothes, lots of, a big bag of  
 240 Barbies, they were that big, a big bag. She jumps up and down and her whole face turns  
 241 into a little (laughs) happy thing.

242 I: That's so cute (laughs) and what does Mum usually do when she is very happy or  
 243 very sad and has to hide it? Or she doesn't want anybody to know?

244 P: She just, her, her eyes sometimes water a little bit and she does, she also keeps  
 245 quiet until she's asked a question.

246 I: Okay and do you think she manages it well to hide it or not so well?

247 P: Mm sometimes she can hide it well and sometimes she just can't hide it.

248 I: Can you think of an example?

249 P: Mm no.

250 I: That's alright, don't worry, and when you have a problem do you feel like you can  
 251 speak to your Mum?

252 P: Yes (smiles) yeah.

253 I: Yeah how do you find speaking to your Mum about it?

254 P: It feels like I am letting out the problem and I don't need to worry about it  
 255 anymore.

256 I: Ah that's so nice, so do you find it helpful?

257 P: Yeah.

258 I: Ah that's great. And would you prefer to speak to Willow or your Dad?

259 P: Mm maybe my Daddy, but Willow is still little so she might not know the answer.

260 I: Yeah that's true, she is younger than you isn't she?

261 P: (nods)

262 I: She's five isn't she?

263 P: Yeah she turned five on this Tuesday.

264 I: And do you prefer to speak to you Mum or your Dad?

265 P: Mummy (smiles).

266 I: Yeah, how come?

267 P: (thinks) I am not sure.

268 I: Don't worry I won't tell them.

269 P: No I am not sure.

270 I: Okay, is it just that it's easier, she is more around or?

271 P: Yes, Daddy is always at work.

272 I: yeah that makes sense but you find it also easy to speak to Dad if you can?

273 P: Yeah.

274 I: That's fantastic. And how do you get on with your sister?

275 P: Mm sometimes we don't get on well and sometimes we get on very well, playing  
 276 games and sometimes we argue but most of the time we are both very happy (smiles)

277 I: Ah that's so nice. That is really nice. And when are you turning nine then?

278 P: This September the 13<sup>th</sup>

279 I: Oh wow, it's in the summer, that's nice. Are you excited?

280 P: Yeah (smiles)

281 I: You don't know what you are doing yet, do you?

282 P: No, but I think we will also gonna go to Chessington (smiles)  
283 I: Did you like it that much (smiles)?  
284 P: (smiles) yeah.  
285 I: Ah great that's so cool, fantastic. Is there anything you would like to ask me?  
286 P: Mm not really (smiles)  
287 I: Okay, well that's the end of the interview, thank you so much Michael for your  
288 help, you have been a massive help

## Appendix XXVII: Further Relevant Example Quotes

### Master-Theme 1: Avoidant ER Style

Participant	Sub-Theme: <i>Cautiousness in disclosing emotions</i>
Monica (Daughter)	<p>"M kind of in the middle because I try and hide it but sometimes people can tell that I am a bit upset." (Monica, 4, 99-100)</p> <p>"I would just try and look normal and just try not to look happy or sad you know and if they ask question I just say you know nothing." (Monica, 4, 106-107)</p>
Linda (Mother) on Michael (Son)	"...even at home when he gets frustrated about something he'll go up in his room and slam the door I think that's his way of you know not, not dealing with it there and then..." (Linda, 14, 446-448)
Nicole (Mother) on Luke (Son)	"...if I get him at the right time before bed and I do try and talk to him as much as possible and he just tries to avoid it as much as possible..." (Nicole, 11, 367-368)
Nicola (Mother) on Richard (Son)	"... if Richard feels like he's been, you know maybe he was in the wrong then he wouldn't talk about it, he would just be like go away, leave me alone, quite often, mm you know I don't know say they had a frac up, kids all play in the street and something happened in the street and he has ended up crying he wouldn't come in and go oh you know so and so hit me, you know, he would just be like go away, leave me alone..." (Nicola, 12, 419-424)
Stacey (Mother) on James (Son)	"M he, he will, actually he is more likely to go upstairs to his room ...we had a phase the slightest thing, he would go to his room and we felt like it was about he would go and hide himself you know..." (Stacey, 22-23, 720-723).

Participant	Sub-Theme: <i>Deflection of embarrassment</i>
Sandra (Mother) on Lewis (Son)	<p>"Mm I think that he's, he's not happy that he's not the, the best (...) Even with Jim (younger brother), if something, Jim we always try and support him and sometimes we say oh he is so good, he wants, he wants recognition, he says no I was better, but you always have to remind him, he is younger (Jim), he (Lewis) always wants to be the first..." (Sandra, 6, 177-183).</p> <p>"Yes and for example he doesn't want, where he is weak he doesn't want to show..." (Sandra, 6, 187).</p>
Stella (Mother) on Tina (Daughter)	<p>"...so rather than getting it wrong she would not speak I guess..." (Stella, 9, 284-285).</p> <p>"...she finds it very hard to say I didn't know or I got that wrong..." (Stella, 10, 294-295)</p> <p>"...if she gets something wrong and you tell her right she'll like, she'll say oh I was going to say that, but there is always a covering up..." (...) "she would kind of get a bit defensive about why it was wrong." (Stella, 10, 292-297),</p> <p>"That's my, that's what I understand obviously I don't see her here very often mm but yeah I think she would avoid, that's her tactic." (Stella, 11, 335-336)</p>
Nicole (Mother) on Luke (Son)	<p>"...so he'll learn how to learn some French and he could do it at home and it was all fine but then he goes to school and he has to do it in front of the class and he acts like an idiot and ended up getting marked down for it." (Nicole, Luke's Mother, 9, 297-300).</p> <p>"...when he came to it he made an arrangement with somebody to laugh at a particular thing when he did something and you see that spoiled the whole thing, cause he was, the teacher pointed that out if you hadn't arranged that silly thing it would have all been fine. It always has to have, there always has to be a laugh." (Nicole, 10, 319-322).</p> <p>"...he's paralysed with what do people think of me, I think he worries about what do people think of me all the time." (Nicole, 9, 300-302).</p> <p>"Yeah he perceives popularity as being able to make people laugh and that's his downfall at the moment." (Nicole, 10, 327-328).</p> <p>"...I just assume that he is showing off and I know that the minute</p>

	he's friends come in the door in the morning to collect him to go to school he instantly changes to a different person like a nob or a clown (laughs)" (Nicole, 10, 330-332).
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Participant	Sub-Theme:  <i>Apprehension of being exposed to the anxiety provoking emotions</i>
Linda (Mother) on Michael (Son)	<p>"I think he was worried that he would get the lines wrong" (Linda, 12, 372)</p> <p>"I think embarrassing himself and people laughing at him and yeah maybe from the teacher's perspective not being able to do what she asked so a bit of both maybe." (Linda, 12, 381-382).</p>
Danielle (Mother) on Ryan (Son)	"...he is always saying they were having a game of this or that and I was just watching or I was just mm the other part, he is always that stand off person and I was tell him to just get involved." (Danielle, 7,199-202)
Nicole (Mother) on Luke (Son)	"...he is not bold enough to cope with situations like that" (Nicole, 9, 314)
Cindy (Mother) on Mark (Son)	<p>"...he would never ever put his hand up, he needs people, he needs to be told he can do it, he needs to know that someone's got the faith in him, so he's not someone to say I'll do it, I'll do it, he needs someone to say oh you would be good at that you can do that." (Cindy, 5, 156-159)</p> <p>"...so I've been in to tell the teacher you know I think he'll be fine he just needs you to say I think you'll be fine, you can do this and when he's done it, he's been amazing but he doesn't, he would never put himself forward." (Cindy, 5 162-164)</p> <p>"...he's very good at chess and he refuses to go into this tournament he refused you know and we always have to leave things for the last minute for him to join in..." (Cindy, 6, 178-180).</p> <p>"...he was clearly worried about losing and looking silly..." (Cindy, 6, 181-182)</p> <p>"...but I have seen him after school have a teacher come up and talk to him about something nice but I've seen him absolute anxiety in his face of having m you know a big authoritative figure</p>

	<p>coming to him..." (Cindy, 6-7, 202-204)</p> <p>"Mm (thinks) I think he just worries about making a fool out of himself and people laughing at him..." (Cindy, 7, 213-214)</p>
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Participant	Sub-Theme:
	<i>Caution in modulating the feared emotional state</i>
Luke	<p>"Well, I was like (pause) just like ok, I just like walked, I just like ran off (pause) with some other friends." (Luke, 1, 29-30).</p> <p>"I was just a bit like, eh not upset but like oh no, just like ahhh, like annoyed and like I need to get out of here oh God." (Luke, 2, 32-33).</p>
Sandra (Mother) on Lewis (Son)	<i>"He is not so strong (...) he seems very strong child but not so strong to accept his weakness and to say this is my weakness and I don't care, I am like this." (Sandra, 7, 195-196).</i>
Cindy (Mother) on Mark (Son)	<i>"...let's say he's been embarrassed he's done something and he's embarrassed himself and he's kind of, he'd just run off and hide so you would have to run after him and it's fine, it's fine, it doesn't matter, whereas, so he can't cope..." (Cindy, 11, 344-346).</i>
Danielle (Mother) on Ryan (Son)	<i>"...just think not very well emotionally equipped for social type things." (Danielle, 5, 147).</i>



## Master-Theme 2: Conflicted ER Style

Participant	Sub-Theme: <i>Struggles to regulate overwhelming, conflictual emotions</i>
Linda (Mother) on Michael (Son)	<p>“Yeah cause I think he, he’s that kind of child who wants to please.” (Linda, 12, 384)</p> <p>“He is still at the age where he wants to the right things, he’s not, he’s not quite oh I don’t care I am too cool, he does want to get things right.” (Linda, 13, 388-389).</p> <p>“...and I think he just pretended that the ball hurt him but I don’t, I don’t think it really hurt him I think he, he’s just, he felt, he didn’t know what to do, he was under pressure and then funny enough, on the way here today we drove (...) and he said “that’s where I did football” and I said “yes, do you want to go back?” and he said “I don’t know, the ball hit me and all the other team mates shouted at me because I let the goal in”.” (Linda, 13-14, 421-426).</p> <p>“...but he doesn’t know what the right thing is, he wants someone to just tell him what the right thing is to do.” (Linda, 16, 510-511)</p> <p>“Yeah, and his Dad will go well he you must do what’s right for you and I think he doesn’t always know what that is you know he still thinks it’s right for him to do what’s gonna make his Dad happy even if he wants to go play with the neighbours.” (Linda, 17, 515-517).</p> <p>“I think sometimes he does, yeah, because he’s, he’s making someone else’s feelings his responsibility.” (Linda, 17, 523-524).</p>
Stella (Mother) on Tina (Daughter)	<p>“...I think she isn’t very emotionally resilient...” (Stella, 268-269)</p>
Mandy (Mother) on Monica (Daughter)	<p>“...then by year six suddenly the, the inhibitions sort of came in a bit more and seeing her in you know piano concert she’d definitely get nervous beforehand and she said her fingers you know she felt like she couldn’t feel the keys because her fingers had gone shaky...” (Mandy, 8, 238-242)</p>

Participant	Sub-Theme: <i>Inability to contain conflictual emotions</i>
Linda (Mother) on Michael (Son)	<p>“Well leading up to the church service he was very nervous, I could see his hands were sweaty and he was fidgety and he was I think he just wanted to get it over with mm but he was excited (smiles) I think there was sort of positive excitement in him as well but I could see he was like (imitates worried face)” (Linda, 13, 393-396)</p> <p>“...he was standing there and the ball came towards him and he didn’t know what to do and one time the ball actually hit him and, and then the ball went back on the field and he just turned his back and I knew he was crying (...)” (Linda, 13-14, 418-421)</p> <p>“...I think, I think probably hiding how he feels cause he does, he does let his emotions out quite easily, he, he will cry or get upset...” (Linda, 14, 443-444)</p> <p>“...he didn’t want the other boys to know mm so I think he, he finds it hard to, to deal with his emotions to know what’s the right reaction to let out there you know...” (Linda, 14, 444-446)</p>
Danielle (Mother) on Ryan (Son)	<p>“...sometimes a bit withdrawing, sometimes he can behave a bit inappropriately, say silly things to annoy people just because he doesn't really know what he can do to probably, to m just fit in, so he tries things perhaps that aren't really, that don't really work very well.” (Danielle, 5, 142-145).</p> <p>“...he does enough silly things to sort of make it harder for other kids to sort of involve him and stuff because he can be a bit silly sometimes...” (Danielle, 6, 179-181)</p> <p>“Yeah impatient and just say when things are not in your control I suppose, you want something to happen and mm I guess when you are enjoying something you want that to go the way you want it to go, you want things to carry on and when that is not quite working out, yeah the anger builds and yeah he just explodes.” (Danielle, 8, 223-226).</p>
Sandra (Mother) on Lewis (Son)	<p>“And ah there was one moment, he arrived mm he was very aggressive to his brother, he was teasing him and I couldn’t understand what happened, he was like so good, all negatives came out so and m I eventually I asked him in the evening, ah no he asked me, he said to me himself, I said how was your</p>

	<p>day and he said there is one boy he is biting me, so it was in Kazakhstan yes so it was explained at least he told me this is good.” (Sandra, 7, 211-216)</p> <p>“Yes. He becomes, usually if he’s emotionally affected as I understood he may not say to me but he will be nervous and mm he will be not so nice, very say no every time when I say something, how to say not agreeing, always not agreeing than yes.” (Sandra, 10, 304-306)</p> <p>“(thinks) mm difficult to imagine because he is mm I just sometimes notice that if he’s offended by me or his mother he, he first of all he will show that he may be too much even then he goes and for a while he’s very down. So he’s a bit I would say him, he doesn’t hold the emotions inside he bursts out he doesn’t come through, he is not so good even to come through I would say. Maybe at school he’s good but at home he shows and this is what I don’t know, sometimes he’s mm if he’s angry it is horrible to see, yes, if he’s angry he’s really bad, but that’s probably like me, because if I am angry I find it also very difficult to control myself and he becomes red he just, he’s like ahh (mimics him angry) in the rage and that’s impossible to do.” (Sandra, 10, 312-320)</p>
Stella (Mother) on Tina (Daughter)	<p>“...I mean, sometimes she’ll be shouting, you know, mm, she is just cross about, when she can’t have her own way, she wants a sweet and I say no, it can blow out of proportion...” (Stella, 12, 366-368).</p> <p>“I think she just gets herself in a, mm, and she would start to cry, and (...) then you can’t stop crying you know...” (Stella, 16-17, 525-528).</p>
Stacey (Mother) on James (Son)	<p>“Mmm (thinks) oh well one of the things that upsets him actually is if he’s made Lego and if I or, we have a cleaner, if she’s moved and broken his Lego when he comes in, he will just be hell for a few minutes, she broke my Lego (imitates) so there is a kind, and that’s sort of provoked by someone else but there is nobody else around so his work, things that he values I think being.” (Stacey, 22, 690-694)</p> <p>“Well he would cry and it’s big (laughs) tears...” (Stacey, 22, 702)</p>

### Master Theme 3: Focused Relational ER Style

Participant	Sub-Theme: <i>Capacity to regulate inhibiting emotions</i>
Luke	<p>“Mm, you just have to (pause), well, if, like, a friend is, like, laughing at you just (pause) either start laughing as a joke, or just, like, ignore them. Or like, eh, so, say you can’t do it you can just maybe just walk away, or just do something else (...) or I just starting laughing as well and I was, like, “Oh I am so rubbish”, like in a funny way.” (Luke, 2, 49-54).</p>
Michael	<p>M: “Oh yeah, we did a Easter service and I had to say some lines in front of the whole church, in front of all the juniors, in front of everyone’s mum and dad and I was embarrassed and scared.” (Michael, 1, 23-25; 22-23 in the appendix).</p> <p>I: ...why do you think you felt nervous or embarrassed?</p> <p>M: “Because I thought that I might say something wrong and everyone would laugh at me.” (Michael, 2, 31-32; 30-31 in the appendix).</p> <p>I: And you did it?</p> <p>M: Yeah (nods)</p> <p>I: And how was it?</p> <p>M: It was okay (smiles). (Michael, 2, 35-38; 34-37 in the appendix).</p>
Richard	<p>“I just eh carried on and (pause) just tried to just not like look at anyone.” (Richard, 2, 37-39)</p>
Linda (Mother) on Michael (Son)	<p>“Mm, I think he probably, mm, in his mind they are probably bigger than they are, mm (thinks), but I think overall he’s, he’s fairly secure in that either he can do it, or if he can’t, it, it won’t be that bad I think. I think he’s got some level of, mm, comfort, I like to think so anyway.” (Linda, Michael’s mother, 13, 402-405).</p>
Mandy (Mother) on Monica (Daughter)	<p>“Mmm she’s far more, she is quite shy to a certain degree as well but m (thinks) she seems quite fearless about performing in public...” (Mandy, 7, 234-235).</p>
Cindy (Mother) on	<p>“...he’s developed emotionally so much over the years mm</p>

Mark (Son)	when he was three or four even going to like a little football class where he might be called to come and do a you know if something with all the other boys sitting there and someone else has to do a little challenge to get the ball of each other, he couldn't cope at all, he would absolutely just stand there with his head down, just couldn't and I just had to sit with him so he has developed so much emotionally over the years..." (Cindy, 5, 149-155).
Stacey (Mother) on James (Son)	"Well, he can cry quite easily, especially for a boy at his age, he can quite, it's very controlled, contained you know, give him a big hug, it's gone..." (Stacey, 21, 664-665).
Stella (Mother) on Tina (Daughter)	"...off she went and she was fine and as far as I know her behaviour was absolutely fine then with us she was very tricky 24 hours before and it started to build and build and she wanted to pull out." (Stella, 10, 319-321)